

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 38501

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Sadie Joan Fairchild

2. Date of Death

Dec. 5, 1997

3. Time of Death

8 AM

4a. Facility Name (If not institution, give street and number)

7633 Maple Ave.

4b. City, Town, or Location of Death

Sykesville

4c. County of Death

Carroll

Funeral
Director

5. Social Security Number

242-32-8533

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

75

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Sept. 7, 1922

9. Birthplace (State or Foreign Country)

N.C.

Usual Residence of Decedent

10a. State

Md.

10b. County

Carroll

10c. City, Town or Location

Sykesville

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

7633 Maple Ave.

10f. Zip Code

21784

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

7

College (1-4 or 5+)

16e. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Domestic

17. Father's Name (First, Middle, Last)

Jesse Pritchard

18. Mother's Name (First, Middle, Maiden Surname)

Lorena (unknown)

19e. Informant's Name/Relationship (Type, Print)

Roscoe M Fairchild (Husband) 7633 Maple Ave. Sykesville, Md. 21784

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

20e. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Lake View Mem. Park 12/9/97 Sykesville, Md

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Hony W. Haight

22. Name and Address of Facility

Haight Funeral Home
P.O. B. 195 Sykesville, MD. 2178423e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

e. Congestive Heart Failure

Due to (or as a consequence of):

2 1/2 years

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Idiopathic Hypertrophic Subaortic Stenosis

Due to (or as a consequence of):

3 years

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

Diabetes

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown24e. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury et
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Robert Kass MD

29c. License number

D34298

29d. Date signed (Month, Day, Year)

12-8-97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Robert Kass, MD 532 Baltimore Blvd Westminster, MD 21157

31. Date filed (Month, Day, Year)

DEC 08 1997

32. Registrar's Signature

John Andrew Randall

State
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38502

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Mary Alice Face

2. Date of Death

Month Dec. 4, Day 1997 Year

3. Time of Death

12:45am

4a. Facility Name (If not Institution, give street and number)

6423 Church Street

4b. City, Town, or Location of Death

Sykesville

4c. County of Death

Carroll

Funeral
Director

5. Social Security Number

215-14-0459

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

75 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Nov. 6, 1922

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Carroll

10c. City, Town or Location

Sykesville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6423 Church Street

10f. Zip Code

21784

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Clerk

16b. Kind of Business/Industry

Clerical

17. Father's Name (First, Middle, Last)

Nicholas McCubbin

18. Mother's Name (First, Middle, Maiden Surname)

Margaret Barrel

19a. Informant's Name/Relationship (Type, Print)

Mr. John Henry Face (Husband)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6423 Church Street, Sykesville, MD 21784

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Lake View Mem. Park

Date

12/8/97

20c. Location - City or Town, State

Sykesville, MD

21. Signature of Funeral Service Licensee

Brian L. Hight

22. Name and Address of Facility

HAIGHT FUNERAL HOME & CHAPEL (Box 195)
Sykesville, MD 21784 (410)-795-1400

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Alzheimer's Disease

Approximate Interval Between Onset and Death

2 yrs

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Steven Billet, M.D.

29c. License number

D27211

29d. Date signed (Month, Day, Year)

12/4/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6190 George town Blvd. Eldersburg MD 21784

31. Date filed (Month, Day, Year)

DEC 08 1997

32. Registrar's Signature

John Andrew Randall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detected for use as the burial-transit

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38503

Baltimore, Maryland 21215-0020
 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Physician
/Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | | | | |
|--|--|---|--|--|--|---|--|
| 1. Decedent's Name (First, Middle, Last) Elva R. Griffin | | | | 2. Date of Death Month Dec. Day 6 Year 1997 | | 3. Time of Death 6:45 am | |
| 4a. Facility Name (If not institution, give street and number) Carroll County General Hospital | | | | 4b. City, Town, or Location of Death Westminster | | 4c. County of Death Carroll | |
| 5. Social Security Number 212 52 7937 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 86 Yrs. | | 8. Date of Birth (Month, Day, Year) Jan. 26, 1911 | |
| 9. Birthplace (State or Foreign Country) Md. | | 10a. State Md. | | 10b. County Carroll | | 10c. City, Town or Location Marriottsville | |
| 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number 2309 Forest Hill Road | | 10f. Zip Code 21104 | | 10g. Citizen of What Country? U.S.A. | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker | | 16b. Kind of Business/Industry Domestic | | 17. Father's Name (First, Middle, Last) Arthur Eugene Rothauge | |
| 18. Mother's Name (First, Middle, Maiden Surname) Eula Lee Waterworth | | 19a. Informant's Name/Relationship (Type, Print) Jean G. Fischer (DAUGHTER) | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip) 2309 Forest Hill Rd. Marriottsville, MD 21104 | | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | |
| 20b. Place of Disposition (Name of cemetery, crematory or other place) Lake View Mem. Park | | 20c. Date 12/9/97 | | 20d. Location - City or Town, State Baltimore, Md. | | 21. Signature of Funeral Service Licensee Brian L. Haight | |
| 22. Name and Address of Facility Haight Funeral Home P.O. Box 195 Sykesville, Md. 21784 | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Myocardial Infarction Due to (or as a consequence of): Coronary Artery Disease | | Approximate Interval Between Onset and Death One day Tenagers | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | |
| 29b. Signature and title of certifier [Signature] | | 29c. License number D33184 | | 29d. Date signed (Month, Day, Year) December 8, 1997 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Emethan Kishner 114 Business Center Drive Pikesville, MD 21136 | |
| 31. Date filed (Month, Day, Year) DEC 08 1997 | | 32. Registrar's Signature Juli Drucker-Randall | | State Registrar | | DHMH 16 Rev 6/95 | |

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

EVA GIBBONS

2. Date of Death
Month Day Year
DECEMBER 6, 19973. Time of Death
3:35AMFuneral
Director

4a. Facility Name (If not institution, give street and number)

BERLIN NURSING AND REHABILITATION CTR BERLIN

4b. City, Town, or Location of Death

4c. County of Death

WORCESTER

5. Social Security Number

408-48-3881

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

92 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

3-15-05

9. Birthplace (State or Foreign Country)

KY

Usual Residence of Decedent

10a. State

MD

10b. County

WORCESTER

10c. City, Town or Location

BERLIN

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3374 OCEAN PINES

10f. Zip Code

21811

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify:

WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

OSCAR LEE SIMMONS

18. Mother's Name (First, Middle, Maiden Surname)

IVY BELIOW

19a. Informant's Name/Relationship (Type, Print)

JOSEPH GIBBONS

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

24 LOOKOUT POINT BERLIN, MD 21811

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☒ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

RUSSELLVILLE CEMETERY

Data

20c. Location - City or Town, State

RUSSELLVILLE, KY

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

ULLRICH FUNERAL HOME BERLIN, MD 21811

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Acute Coronary Occlusion Minutes -

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Coronary Artery Disease 7 yr

Due to (or as a consequence of):

c. Atherosclerosis

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Semi I. E.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of injury (Month, Day Year)

28b. Time of injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

#BA0822331

29d. Date signed (Month, Day, Year)

12-6-97,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

E. CASARNOVA 9715 HATHAWAY DR. BERLIN MD 21811

31. Date filed (Month, Day, Year)

DEC 08 1997

32. Registrar's Signature

Julia Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **97 38505**
Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Jean Fisher Hall

2. Date of Death

Month Day Year
12 2 97

3. Time of Death

0025

4a. Facility Name (If not institution, give street and number)

PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death

SALISBURY

4c. County of Death

WICOMICO

5. Social Security Number

220-26-3465

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

69 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year
11-30-28

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

MD

10b. County

Worcester

10c. City, Town or Location

Pocomoke City

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

635 Cedar Hall Rd

10f. Zip Code

21851

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: WHITE

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (14 or 5+)

2

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

comptroller

16b. Kind of Business/Industry

Federal Government

17. Father's Name (First, Middle, Last)

Marvin Fisher, SR

18. Mother's Name (First, Middle, Maiden Surname)

Etta Drummond

19a. Informant's Name/Relationship (Type, Print)

Willard Dale Hall, SR

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

635 Cedar Hall Rd Pocomoke City, MD 21851

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

First Baptist Cemetery

Date

12-5-97

20c. Location - City or Town, State

Pocomoke, MD

21. Signature of Funeral Service Licensee

Michael A. Dean

22. Name and Address of Facility

Holloway Melson Funeral Home

Pocomoke City, MD 21851

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)a. Septicemia
Due to (or as a consequence of):b. Renal Failure
Due to (or as a consequence of):c. Non Small Cell Lung Cancer
Due to (or as a consequence of):

d.

Sequently list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) LastApproximate
interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation
6 ☐ Could not be determined

28a. Date of injury

(Month, Day Year)

28b. Time of injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Joseph W. Grasso

29c. License number

D 20507

29d. Date signed (Month, Day, Year)

12/4/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Joseph W. Grasso 145 E. CARROLL ST SALISBURY MD

31. Date filed (Month, Day, Year)

DEC 08 1997

32. Registrar's Signature

John Davidson-Randall

State
Registrar

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

X

S

X

X

X

Now is your chance

2. second edition

is a new book and will be
very useful to you

Thank you very much

very truly yours

Yours faithfully

X

Yours faithfully

C

Yours faithfully

Yours faithfully

Yours faithfully

Yours faithfully

Yours faithfully

Yours faithfully

Yours faithfully

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

38506

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

DOROTHY M. JOHNSON

2. Date of Death

11 Month 27 Day 97 Year 2000

3. Time of Death

4a. Facility Name (If not Institution, give street and number)

506 EDGEWATER

4b. City, Town, or Location of Death

OCEAN CITY

4c. County of Death

WORCESTER

Funeral
Director

5. Social Security Number

213-05-4944

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

86 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

6-6-11 (Month, Day, Year)

9. Birthplace (State or Foreign Country)

MD.

Usual Residence of Decedent

10a. State

MD

10b. County

WORCESTER

10c. City, Town or Location

OCEAN CITY

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

506 EDGEWATER

10f. Zip Code

21842

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married

3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

SECRETARY

16b. Kind of Business/Industry

INSURANCE

17. Father's Name (First, Middle, Last)

HARRY DUMPHY

18. Mother's Name (First, Middle, Maiden Surname)

WINIFRED FINDLING

19a. Informant's Name/Relationship (Type, Print)

ROBERT A. JOHNSON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10124 NORTH AVE. OCEAN CITY, MD. 21842

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

SUNSET MEMORIAL PARK

Date

11-30

20c. Location - City or Town, State

BERLIN, MD.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

ULLRICH FUNERAL HOME BERLIN, MD. 21811

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Coronary Artery Disease

Due to (or as a consequence of):

Years

b. Chronic Obstructive Pulmonary Disease

Due to (or as a consequence of):

Years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☒ Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural

2 ☐ Accident

3 ☐ Suicide

4 ☐ Homicide

5 ☐ Pending investigation

6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D 36783

29d. Date signed (Month, Day, Year)

12/2/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jeffrey E. Harton, MD

PRMO Salisbury, MD 21801

31. Date filed (Month, Day, Year)

DEC 05 1997

32. Registrar's Signature

Jula Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38507

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permitted. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician /Medical Examiner

Funeral Director

| | | | | |
|---|--|---|--|--|
| 1. Decedent's Name (First, Middle, Last) Norman J. Lawrence | | 2. Date of Death Month: December, Day: 5, Year: 1997 | | 3. Time of Death 10:50 a.m. |
| 4a. Facility Name (If not institution, give street and number) Frederick Memorial Hospital | | 4b. City, Town, or Location of Death Frederick | | 4c. County of Death Frederick |
| 5. Social Security Number 213-88-5340 | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 70 Yrs. | 8. Date of Birth (Month, Day, Year) Aug. 28, 1927 | 9. Birthplace (State or Foreign Country) Maryland |
| Usual Residence of Decedent | | | | |
| 10a. State Maryland | 10b. County Carroll | 10c. City, Town or Location Taneytown | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 10e. Street and Number 3165 Hyser Road | | 10f. Zip Code 21787 | | 10g. Citizen of What Country? U.S.A. |
| 11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |
| 14. Race - American Indian, Black, White, etc. Specify: Caucasian | | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7th College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Farmer | | 16b. Kind of Business/Industry Agriculture |
| 17. Father's Name (First, Middle, Last) Norman H. Lawrence | | 18. Mother's Name (First, Middle, Maiden Surname) Blanch B. Feeser | | |
| 19a. Informant's Name/Relationship (Type, Print) Allen Lawrence/Brother | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10917 Harney Rd., Emmitsburg, MD 21727 | | |
| 20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Smithsburg Crematory | | 20c. Location - City or Town, State Smithsburg, MD |
| 21. Signature of Funeral Service Licensee <i>John M. Skiles</i> MO0534 | | 22. Name and Address of Facility Skiles Funeral Home 136 E. Baltimore St., Taneytown, MD 21787 | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. <i>Brain stem infarction</i> Due to (or as a consequence of): b. <i>Sepsis</i> Due to (or as a consequence of): c. <i>Hypertension</i> Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | Approximate Interval Between Onset and Death |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>None</i> | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |
| | | | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |
| | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) — | 28b. Time of Injury — M | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |
| | | 28d. Describe how injury occurred — | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) — |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | |
| 29b. Signature and title of certifier <i>Robert L. Love</i> | | 29c. License number D20422 | | 29d. Date signed (Month, Day, Year) 12/5/97 |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <i>Robert L. Love 188 Thomas Johnson St., Frederick, Md. 21701</i> | | | | |
| 31. Date filed (Month, Day, Year) DEC 08 1997 | | 32. Registrar's Signature <i>John A. Carroll</i> | | |

State Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38508

| | | | | | | | | |
|---|---|---|--|--|---|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Francis A. Martin | | | | 2. Date of Death Month December Day 5 Year 1997 | | 3. Time of Death 8:05 pm | |
| | 4a. Facility Name (If not institution, give street and number) 2527 Cornstalk Drive | | | | 4b. City, Town, or Location of Death Finksburg | | 4c. County of Death Carroll | |
| Funeral Director | 5. Social Security Number 218-07-8681 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 76 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) Dec. 31, 1920 | 9. Birthplace (State or Foreign Country) Maryland |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State MD | | 10b. County Carroll | | 10c. City, Town or Location Finksburg | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 10e. Street and Number 2527 Cornstalk Drive | | | | 10f. Zip Code 21048 | | 10g. Citizen of What Country? United States | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WWII | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) worked Production | | 16b. Kind of Business/Industry Western Electric | | |
| 17. Father's Name (First, Middle, Last) Francis Augustus Martin | | | | 18. Mother's Name (First, Middle, Maiden Surname) Margaret Reiser | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Mary Bandorick, daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 329 Stacey Lee Drive, Westminster, MD 21158 | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Crestlawn Memorial Gardens | | Date 12/09/97 | | 20c. Location - City or Town, State Marriottsville, MD | | |
| 21. Signature of Funeral Service Licensee Katherine Prieto - Sweitzer | | | | 22. Name and Address of Facility Prieto's Funeral Home & Chapel 412 Washington Rd., Westminster, MD 21157 | | | | |
| 23a. Pertinent disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. METASTATIC ESOPHAGEAL CANCER | | | | | | | | Approximate Interval Between Onset and Death 1 yr |
| Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): | | | | | | | | |
| Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): | | | | | | | | |
| Due to (or as a consequence of): | | | | | | | | |
| Due to (or as a consequence of): | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| | | | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred |
| | | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and Title of certifier Flavio Kruter MD | | | | 29c. License number D35398 | | 29d. Date signed (Month, Day, Year) Dec 8, 1997 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Flavio Kruter, MD 684 A Poole Rd Westminster, MD 21157 | | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 08 1997 | | 32. Registrar's Signature John Anderson-Randall | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38509

| | | | | | | | | |
|---|---|---|---|--|--|---|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Mae Victoria Mariner | | | | 2. Date of Death Month December Day 02 Year 1997 | | 3. Time of Death 9:10 am | |
| | 4a. Facility Name (If not institution, give street and number) Wicomico Nursing Home | | | | 4b. City, Town, or Location of Death Salisbury | | 4c. County of Death Wicomico | |
| Funeral Director | 5. Social Security Number 214-28-3495 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (in yrs. last birthday) 96 Yrs. | | 8. Date of Birth (Month, Day, Year) 7-27-01 | |
| | 9. Birthplace (State or Foreign Country) Maryland | | 10a. State MD | | 10b. County Worcester | | 10c. City, Town or Location Pocomoke City, MD | |
| To Be Completed by Funeral Director | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number Clarke Manor Apts. | | 10f. Zip Code 21851 | | 10g. Citizen of What Country? USA | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: white | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4 or 5+) 4 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) homemaker | | 16b. Kind of Business/Industry domestic | | | |
| | 17. Father's Name (First, Middle, Last) Herbert Bishop Mills | | | | 18. Mother's Name (First, Middle, Maiden Summa) Bessie Brittingham | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Wm. Bentley Mariner | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 344 Sharptown, MD 21861 | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Salem United Meth. Cem | | Date 12-6-97 | | 20c. Location - City or Town, State Pocomoke, MD | |
| | 21. Signature of Funeral Service Licensee Michael A Dean | | | | 22. Name and Address of Facility Holloway Melson Funeral Home Pocomoke City, MD 21851 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): a. terminal pneumonia Due to (or as a consequence of): b. aspiration (H16 tube) Due to (or as a consequence of): c. Anterior Leukosis Dementia Fin Due to (or as a consequence of): d. </div> <div style="width: 15%; text-align: center;"> Approximate Interval Between Onset and Death 1 week </div> </div> | | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | | 28d. Describe how injury occurred | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier [Signature] | | | | 29c. License number D02026 | | 29d. Date signed (Month, Day, Year) Dec 3-97 | | |
| 30. Name and address of person who completed cause of death (item 23e) (Type, Print) Federico G. Arthes, MD 1622A Ocean Pines Berlin, MD 21811 | | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 08 1997 | | | | 32. Registrar's Signature [Signature] | | | | |

Baltimore, Maryland 21215-0020

Mariner, Mae

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38510

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician
/Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | | | | | | |
|--|--|---|--|--|---|---|---|--|--|
| 1. Decedent's Name (First, Middle, Last) MATTIE L. NIBLETT | | | | 2. Date of Death Month DECEMBER Day 09 Year 1997 | | | | 3. Time of Death 6:30 PM | |
| 4a. Facility Name (If not institution, give street and number) Berlin Nursing and Rehabilitation Center | | | | 4b. City, Town, or Location of Death Berlin | | | | 4c. County of Death Worcester | |
| 5. Social Security Number 213-22-6218 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 93 Yrs. | | 8. Date of Birth (Month, Day, Year) 9/25/04 | | 9. Birthplace (State or Foreign Country) MD | |
| Usual Residence of Decedent | | | | | | | | | |
| 10a. State MD | | 10b. County Worcester | | 10c. City, Town or Location Ocean City | | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10e. Street and Number 10320 North RD | | | | 10f. Zip Code 21842 | | 10g. Citizen of What Country? USA | | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: white | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker | | | 16b. Kind of Business/Industry Home | | |
| 17. Father's Name (First, Middle, Last) Jessie T. Birch | | | | | 18. Mother's Name (First, Middle, Maiden Surname) Arlanta Merritt | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Russell Bradford/ Son | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 401 15th St. #12 Ocean City, MD 21842 | | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Evergreen Cemetery | | Date 12/12/97 | | 20c. Location - City or Town, State Berlin, MD | |
| 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility Burbage Funeral Home 108 William St. Berlin, MD 21811 | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Congestive Heart Failure months Due to (or as a consequence of): b. Coronary Artery Disease year Due to (or as a consequence of): c. Diffuse Atherosclerosis year Due to (or as a consequence of): d. | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Bronchitis - Myocardial Infarction - Recent onset Chronic Obstructive Pulmonary Disease | | | | | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how Injury occurred | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| 29b. Signature and title of certifier | | | | 29c. License number D02026 | | 29d. Date signed (Month, Day, Year) Dec 10-97 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FEDERICO G. ARTES, 1622A OCEAN PINES, BERLIN, MD 21811 | | | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 11 1997 | | | | 32. Registrar's Signature | | | | | |

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38511

| | | | | | | | | | | |
|-------------------------------------|--|--|---|--|--|--|---|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) MARTHA ROSE POLANSKAS | | | | | | 2. Date of Death Month Day Year DEC 7, 1997 | | 3. Time of Death 3:37 PM | |
| | 4a. Facility Name (If not institution, give street and number) LONG VIEW NURSING HOME | | | | | | 4b. City, Town, or Location of Death MANCHESTER | | 4c. County of Death CARROLL | |
| Funeral Director | 5. Social Security Number 217-01-1670 | | 8. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 83 Yrs. | | If Under 1 Year Months Days | | If Under 24 Hrs. Hours Min. | |
| | 6. Date of Birth (Month, Day, Year) NOV 17, 1914 | | 9. Birthplace (State or Foreign Country) MARYLAND | | Usual Residence of Decedent | | 10e. State MARYLAND | | 10b. County CARROLL | |
| To Be Completed by Funeral Director | 10c. City, Town or Location HAMPSTEAD | | | | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10f. Street and Number 610 S. HOUCKSVILLE ROAD | |
| | 10g. Zip Code 21074 | | 10h. Citizen of What Country? USA | | 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | |
| | 14. Race - American Indian, Black, White, etc. Specify: WHITE | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOUSEWIFE | | 16b. Kind of Business/Industry OWN HOME | | 17. Father's Name (First, Middle, Last) FRANK JARKIEWICZ | |
| | 18. Mother's Name (First, Middle, Maiden Surname) PAULINE TWARDOWSKI | | 19a. Informant's Name/Relationship (Type, Print) CHARLES POLANSKAS, HUSBAND | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 610 S. HOUCKSVILLE RD, HAMPSTEAD, MD 21074 | | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) HOLY CROSS CEMETERY | |
| | 20c. Date 10/12 | | 20d. Location - City or Town, State BALTIMORE, MD | | 21. Signature of Funeral Service Licensee <i>Steven W. Eline</i> | | 22. Name and Address of Facility ELINE FUNERAL HOME 934 SOUTH MAIN ST, HAMPSTEAD, MD 21074 | | 23a. Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. e. <i>Coronary Heart failure</i> Due to (or as a consequence of): f. <i>Uterine Cancer</i> Due to (or as a consequence of): g. Due to (or as a consequence of): h. Due to (or as a consequence of): | |
| | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | |
| | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how Injury occurred | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier <i>John M. ...</i> | | 29c. License number D25443 | |
| | 29d. Date signed (Month, Day, Year) 12/8/97 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 688 Poole Road Westminster, Md 21157 | | 31. Date filed (Month, Day, Year) DEC 08 1997 | | 32. Registrar's Signature <i>John M. ...</i> | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38512

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

HELEN E. POOL

2. Date of Death

Month Day Year
12 3 1997

3. Time of Death

12:00

4a. Facility Name (If not institution, give street and number)

PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death

SALISBURY

4c. County of Death

WICOMICO

5. Social Security Number

577-07-8137

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

89 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

3-20-08

9. Birthplace (State or Foreign Country)

GA.

Usual Residence of Decedent

10a. State

MD.

10b. County

WORCESTER

10c. City, Town or Location

OCEAN CITY

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

12917 CHARLES STREET

10f. Zip Code

21842

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

TILLMAN FUNK

18. Mother's Name (First, Middle, Maiden Surname)

AZILEE BORING

19a. Informant's Name/Relationship (Type, Print)

HELEN B. BOLTON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12917 CHARLES STREET OCEAN CITY, MD., 21842

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

SALISBURY CREMATORY

Data

12-4

20c. Location - City or Town, State

SALISBURY, MD.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

ULLRICH FUNERAL HOME BERLIN, MD., 21811

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Bilal pneumonia

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

6 d

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Bilal pleural effusions

Cellulitis Leg

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D 47619

29d. Date signed (Month, Day, Year)

12/3/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

OSCAR GUALTEROS MD 262 Tilghman Rd, Salisbury MD 21804

31. Date filed (Month, Day, Year)

DEC 05 1997

32. Registrar's Signature

Julie Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

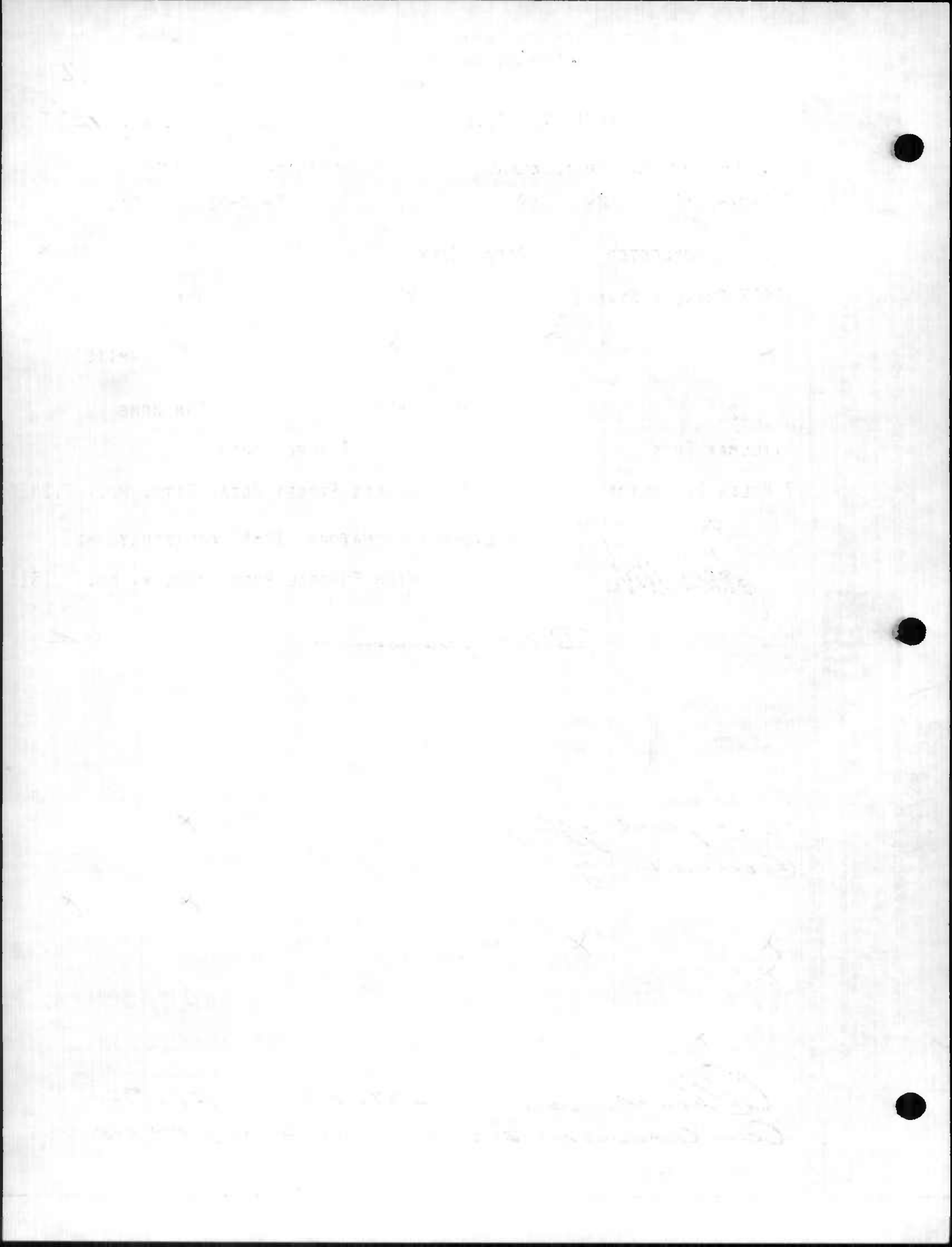
Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760, Helen Pool



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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38513

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ROLAND S. PEREGOY

2. Date of Death

Month 12 Day 5 Year 97

3. Time of Death

1307

Funeral
Director

4a. Facility Name (If not institution, give street and number)

PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death

SALISBURY

4c. County of Death

WICOMICO

5. Social Security Number

212-20-4641

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

73 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
7-31-24

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

WORCESTER

10c. City, Town or Location

OCEAN CITY

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

14203 COASTAL HWAY 3A

10f. Zip Code

21842

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: WHITE

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

SECURITY

16b. Kind of Business/Industry

BALTIMORE GAS & ELEC

17. Father's Name (First, Middle, Last)

HAGEY PEREGOY

18. Mother's Name (First, Middle, Maiden Surname)

CARRIE

19a. Informant's Name/Relationship (Type, Print)

BARBARA A. PEREGOY

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

14230 COASTAL HWAY 3A OCEAN CITY, MD 21842

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

DRUID RIDGE CEMETERY

Date

12-8

20c. Location - City or Town, State

BALTIMORE, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

ULLRICH FUNERAL HOME BERLIN, MD 21811

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
stroke, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)a. Multi-system organ failure
Due to (or as a consequence of):Approximate
Interval Between
Onset and Death

2 months

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Lastb. Mediastinal and abdominal aortic aneurysms
Due to (or as a consequence of):

1 to 4 wks.

c. Partial gastrectomy for gastric polyps & bleeding
Due to (or as a consequence of):

6 wks.

d. Coronary bypass for unstable

Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.

Decubitus ulcer on sacrum

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending
2 ☐ Accident investigation
3 ☐ Suicide 6 ☐ Could not be
4 ☐ Homicide determined28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D 02038

29d. Date signed (Month, Day, Year)

12/5/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

741 201 Pine Bluff Road Suite 25, Salisbury, Md, 21801

31. Date filed (Month, Day, Year)

DEC 8 1997

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

Roland Peregoy

212-20-4641

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38514

| | | | | | |
|--|--|---|---|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Rebecca Childs Ritter | | 2. Date of Death Month December Day 5 Year 1997 | | 3. Time of Death 6:12 AM |
| | 4e. Facility Name (If not institution, give street and number) Salisbury Center: Genesis ElderCare | | 4b. City, Town, or Location of Death Salisbury, MD | | 4c. County of Death Wicomico |
| Funeral Director | 5. Social Security Number 214-01-0936 | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 78 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. |
| | 8. Date of Birth (Month, Day, Year) 10/11/19 | | 9. Birthplace (State or Foreign Country) MD | | |
| Usual Residence of Decedent | | | | | |
| 10e. State MD | | 10b. County Baltimore City | | 10c. City, Town or Location Baltimore | |
| 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| 10e. Street and Number 3939 Roland Ave. | | 10f. Zip Code 21211 | | 10g. Citizen of What Country? USA | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever In U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | |
| 14. Race - American Indian, Black, White, etc. Specify: white | | | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) | | 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Sales | | 16b. Kind of Business/Industry Shoe Store | |
| 17. Father's Name (First, Middle, Last) Lawrence Childs | | 18. Mother's Name (First, Middle, Maiden Surname) Grace Armicost | | | |
| 19a. Informant's Name/Relationship (Type, Print) Lawrence Ritter/ Son | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9748 Carmody Lane W. Ocean City, MD 21842 | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Grave Run Cemetery | | 20c. Location - City or Town, State 12/9/97 Hampstead, MD | |
| 21. Signature of Funeral Service Director | | 22. Name and Address of Facility Burbage Funeral Home 108 William St. Berlin, MD 21811 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Complications of Advanced Dementia Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | 23b. Part II. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death years | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | |
| 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier | | 29c. License number D-39813 | |
| 29d. Date signed (Month, Day, Year) 12/15/97 | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MATKINS MD 1104 Healthway Dr., Salisbury, MD 21804 | | | | | |
| 31. Date filed (Month, Day, Year) DEC 08 1997 | | 32. Registrar's Signature | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Sylvia Louise Sell

2. Date of Death

Month

Day

Year

12 05 97 10:45pm

3. Time of Death

Funeral
Director

4a. Facility Name (If not institution, give street and number)

St. Catherines Nursing Center

4b. City, Town, or Location of Death

Emmitsburg

4c. County of Death

Frederick

5. Social Security Number

215-26-7923

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

87

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

April 9, 1910

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Carroll

10c. City, Town or Location

Taneytown

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

223 E. Baltimore St.

10f. Zip Code

21787

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Caucasian

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8th

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

William Zurgable

18. Mother's Name (First, Middle, Maiden Surname)

Mary McGrath

19a. Informant's Name/Relationship (Type, Print)

M. Patricia Brown/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8127 Gray Haven Rd., Baltimore, MD 21222

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Trinity Lutheran Cem.

Date

12/09

20c. Location - City or Town, State

Taneytown, Maryland

21. Signature of Funeral Service Licensee

John M. Skiles M00534

22. Name and Address of Facility

Skiles Funeral Home

136 E. Baltimore St., Taneytown, MD 21787

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Deep coma with respiratory arrest

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Encephalitis - viral

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 weeks
1 month

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Bonita J. Krempel-Portier H44037

29c. License number

29d. Date signed (Month, Day, Year)

DECEMBER 6, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BINITA J. KREMPEL-PORTIER, D.O. 310 S. SETON AVE., EMMITSBURG, MD. 21727

31. Date filed (Month, Day, Year)

DEC 08 1997

32. Registrar's Signature

Julia Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38516

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ALFRED Scarborough

2. Date of Death

November 28, 1997

3. Time of Death

2:58

4a. Facility Name (If not institution, give street and number)

PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death

SALISBURY

4c. County of Death

WICOMICO

Funeral
Director

5. Social Security Number

223-246752

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

75 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

8-6-22

9. Birthplace (State or Foreign Country)

VIRGINIA

Usual Residence of Decedent

10a. State

VA

10b. County

Accomack

10c. City, Town or Location

ATLANTIC

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

33003 Wishart Point Rd

10f. Zip Code

23303

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BIK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

SERVICE MAN

16b. Kind of Business/Industry

HEATING & Air cond. etc.

17. Father's Name (First, Middle, Last)

Julian Scarborough

18. Mother's Name (First, Middle, Maiden Surname)

Julie Allen

19a. Informant's Name/Relationship (Type, Print)

Doris Scarborough wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

33003 Wishart Point Rd ATLANTIC, VA 23303

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

ST Johns

Date

12/6/97 ATLANTIC, VA.

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Keith E. Wharton

22. Name and Address of Facility

WHARTON Funeral Home
22171 Wharton Rd Accomack, VA 23301

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. RESPIRATORY FAILURE

Due to (or as a consequence of):

b. SQUAMOUS CELL CARCINOMA OF THE LUNG

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 WEEK

22 YEARS.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

MEDICAL STAFF

29c. License number

D46024

29d. Date signed (Month, Day, Year)

NOVEMBER 28 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

ABRIL K. GARBA, MD, TLC, 12137 ELM STREET, PRINCESS ANN, MD 21853

31. Date filed (Month, Day, Year)

DEC 05 1997

32. Registrar's Signature

John Davidson-Randall

State
Registrar

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38517

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

Myrtle Marie Stevens

2. Date of Death

Month
December

Day

04

Year

1997

3. Time of Death

2:25 am

4a. Facility Name (If not institution, give street and number)

Wicomico Nursing Home

4b. City, Town, or Location of Death

Salisbury

4c. County of Death

Wicomico

5. Social Security Number

215-16-3454

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

79 Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)
10-21-18

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Worcester

10c. City, Town or Location

Pocomoke City, MD

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1749 Cedar Hall Rd

10f. Zip Code

21851

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

11

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

store clerk

16b. Kind of Business/Industry

retail

17. Father's Name (First, Middle, Last)

Robert C. Hurley

18. Mother's Name (First, Middle, Maiden Surname)

Adell East

19a. Informant's Name/Relationship (Type, Print)

Helen Hart

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

217 Eleventh St. Pocomoke, MD 21851

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Salem Meth.Ch.Cemetery 12-7-97 Pocomoke, MD

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Holloway Melson Funeral Home

103 Linden Ave. Pocomoke, MD 21851

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Acute Myocardial Infarction

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Arteriosclerotic Vascular Disease

Due to (or as a consequence of):

c. Diffuse Arteriosclerosis

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Sensitivity.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D02026

29d. Date signed (Month, Day, Year)

12-4-97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Federico G. Arthes, MD 1622A Ocean Pines Berlin, MD 21811

31. Date filed (Month, Day, Year)

DEC 08 1997

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Stevens, Myrtle Marie

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38518

| | | | | | | | | |
|--|---|---|---|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) EDWARD LEE TAYLOR | | | | 2. Date of Death Month 12 Day 5 Year 97 | | 3. Time of Death 10:56 AM | |
| | 4a. Facility Name (If not institution, give street and number) Atlantic General Hospital | | | | 4b. City, Town, or Location of Death Berlin | | 4c. County of Death Worcester | |
| Funeral Director | 5. Social Security Number 218-14-2655 | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 87 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) 6/16/10 | 9. Birthplace (State or Foreign Country) MD | |
| | Usual Residence of Decedent | | | | | | | |
| To Be Completed by Funeral Director | 10a. State MD | 10b. County Worcester | 10c. City, Town or Location Berlin | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | 10e. Street and Number 11309 Assateague RD | | | 10f. Zip Code 21811 | | 10g. Citizen of What Country? USA | | |
| | 11. Marital Status <input type="checkbox"/> Navar Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1941 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: white | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7 College (1-4or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Carpenter | | | 16b. Kind of Business/Industry Construction | | |
| | 17. Father's Name (First, Middle, Last) Joseph William Taylor | | | | 18. Mother's Name (First, Middle, Maiden Summa) Virginia Spence Harman | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) Mary L. Caine/ Daughter | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10242 Bent Creek RD Ocean City, MD 21842 | | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Sunset Memorial Park | | Date 12/8/97 | 20c. Location - City or Town, State Berlin, MD | | |
| | 21. Signature of Funeral Service Licensee <i>[Signature]</i> | | | 22. Name and Address of Facility Burbage Funeral Home 108 William St. Berlin, MD 21811 | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Sudden Death / Coronary Artery Disease Due to (or as a consequence of): b. Parkinson's Disease / Sky-Drage Syn Due to (or as a consequence of): c. Dementia Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | Approximate Interval Between Onset and Death 1 hr Years " |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury M | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | 28d. Describe how injury occurred | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier Bill Green, MD | | 29c. License number D-35764 | | 29d. Date signed (Month, Day, Year) 12/5/97 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bill Green 124 N. Mann St. Berlin, Md 21811 | | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 08 1997 | | 32. Registrar's Signature Julia Davidson-Randall | | | | | | |

Baltimore, Maryland 21215-0020
 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,
 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar
 10-1

Amended Item #20a, per F.D. 12/8/97, Carroll County, will

Certificate of Death

Reg. No.

97 38519

| | | | | | | | | | | | | | | | | | | | |
|---|--|---|--|---|--|---|--|--|--|--|--|--|--|--|--|--|--|---|--|
| Physician /Medical Examiner | | 1. Decedent's Name (First, Middle, Last) Viola Vaughan | | | | | | 2. Date of Death Month Day Year Dec. 4 1997 | | 3. Time of Death 9:00 pm | | | | | | | | | |
| Funeral Director | | 4a. Facility Name (If not institution, give street and number) Sykesville Elder Care | | | | 4b. City, Town, or Location of Death Sykesville | | | | 4c. County of Death Carroll | | | | | | | | | |
| To Be Completed by Funeral Director | | 5. Social Security Number 212 10 5423 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 85 Yrs. | | If Under 1 Year Months Days | | If Under 24 Hrs. Hours Min. | | 8. Date of Birth (Month, Day, Year) March 16, 1912 Md. | | 9. Birthplace (State or Foreign Country) | | | | | |
| | | Usual Residence of Decedent | | | | | | | | | | | | | | | | | |
| | | 10a. State Md. | | 10b. County Carroll | | 10c. City, Town or Location Sykesville | | | | | | 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | |
| | | 10e. Street and Number 7309 Second Ave. | | | | | | 10f. Zip Code 21784 | | | | 10g. Citizen of What Country? U.S.A. | | | | | | | |
| | | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify White | | | | | | | | | |
| | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 8 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Welder | | | | 16b. Kind of Business/Industry Stove Co. | | | | | | | | | |
| | | 17. Father's Name (First, Middle, Last) William Goodrich | | | | | | 18. Mother's Name (First, Middle, Maiden Surname) Martha Klemm | | | | | | | | | | | |
| | | 19a. Informant's Name/Relationship (Type, Print) Janice A. Grimm (DAUGHTER) | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 511 Tanglewood Dr. Sykesville, Md. 21784 | | | | | | | | | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Carroll Cremation Service | | | | Date 12/5/97 | | 20c. Location - City or Town, State Hampstead, Md. | | | | | | | | | | | |
| 21. Signature of Funeral Service Licensee Harry W. Haight | | | | | | 22. Name and Address of Facility Haight Funeral Home P.O.Box 195 Sykesville, Md. 21784 | | | | | | | | | | | | | |
| Physician /Medical Examiner | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. Atherosclerotic Coronary Vessel Disease Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ | | | | | | | | | | | | | | Approximate Interval Between Onset and Death 10yr | | | |
| Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020 | | Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. | | | | | | | | | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | |
| | | | | | | | | | | | | | | | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA | | Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) | | | | | | | | | | | | | |
| | | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accidental 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | | | | | | | | |
| State Registrar | | 30. Name and address of person who completed causa of death (Item 23a) (Type, Print) Robert L. Mori 114 Burner Center Dr. Reisterstown, Md 21156 | | | | | | | | | | | | | | | | | |
| | | 31. Data filed (Month, Day, Year) DEC 08 1997 | | | | 32. Registrars Signature [Signature] | | | | | | | | | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Items: 24a,25,29a Per Phy Film G-754 12/20/97RC

Certificate of Death

Reg. No.

77 38520

| | | | | | | | | | |
|---|---|---|---|--------------------------------|--|--|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Raymond J. Donaldson Jr. | | | | 2. Date of Death Month: December Day: 6 Year: 1997 | | 3. Time of Death 2:00 a.m. | | |
| | 4a. Facility Name (If not Institution, give street and number) 6506 Baltimore Avenue | | | | 4b. City, Town, or Location of Death Hyattsville | | 4c. County of Death Prince Georges | | |
| Funeral Director | 5. Social Security Number 218-12-4874 | 6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 7. Age (In yrs. last birthday) Yrs. 73 | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) April 15, 1924 | | 9. Birthplace (State or Foreign Country) Maryland | |
| | Usual Residence of Decedent | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State Maryland | | 10b. County Prince Georges | | 10c. City, Town or Location Hyattsville | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| | 10e. Street and Number 6506 Baltimore Avenue | | | 10f. Zip Code 20782 | | 10g. Citizen of What Country? U.S.A. | | | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: 1943-46 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 4 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Engineer | | | 16b. Kind of Business/Industry | | | |
| | 17. Father's Name (First, Middle, Last) Raymond Joseph Donaldson | | | | 18. Mother's Name (First, Middle, Maiden Summa) Vera Elizabeth Carney | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) Mary Donaldson/wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6506 Baltimore Avenue, Baltimore, Maryland 20782 | | | | |
| | 20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) | | Date | | 20c. Location - City or Town, State | | |
| | 21. Signature of Funeral Service Licensee Ronald S. Wade, Director | | | | 22. Name and Address of Facility State Anatomy Board, 655 W. Baltimore Street Baltimore, Maryland 21201 | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) CEREBRAL AND CEREBELLAR DEGENERATION UNCERTAIN ETIOLOGY/ Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): | | | | | | | Approximate Interval Between Onset and Death 2 YEARS | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CORONARY ARTERY DISEASE | | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier Mark Parkhurst MD | | 29c. License number D24093 | | 29d. Date signed (Month, Day, Year) 12/11/97 | | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) MARK PARKHURST MD 7305 BALTIMORE AVE COLLEGE PARK, MD | | | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 20 1997 | | 32. Registrar's Signature John Davidson-Randall | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Item: 8 Per FH Film G-754 12-20-97RC

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38521

| | | | | | | | | |
|---|---|--|---|--|---|--|--|---|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) MELVIN SMITH | | | | 2. Date of Death Month DECEMBER Day 18 Year 97 | | 3. Time of Death 3:32 AM | |
| | 4a. Facility Name (If not institution, give street and number) NORTHWEST HOSPITAL CENTER | | | | 4b. City, Town, or Location of Death RANDALLSTOWN | | 4c. County of Death BALTIMORE | |
| Funeral Director | 5. Social Security Number 220-20-2206 | | 6. Sex 1 M 2 F | | 7. Age (In yrs. last birthday) 67 Yrs. | | 8. Date of Birth (Month, Day, Year) July 22, 1930 | |
| | 9. Birthplace (State or Foreign Country) Maryland | | 10a. State Maryland | | 10b. County Baltimore | | 10c. City, Town or Location Randallstown | |
| To Be Completed by Funeral Director | 10d. Inside City Limits 1 Yes 2 No | | 10e. Street and Number 3925 Rockfield Road | | 10f. Zip Code 21118 | | 10g. Citizen of What Country? U.S.A | |
| | 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Black | |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7th College (1-4 or 5+) N/A | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Laborer | | 16b. Kind of Business/Industry Poultry | | 17. Father's Name (First, Middle, Last) George Smith | |
| | 18. Mother's Name (First, Middle, Maiden Surname) Gladys Abrams | | 19a. Informant's Name/Relationship (Type, Print) Annette Woodley - niece | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1813 Druidhill Avenue, Baltimore, MD | | 20a. Method of Disposition 1 Burial 2 <input checked="" type="checkbox"/> Cremation 3 Removal from State 4 Donation 5 Other (Specify) | |
| Physician /Medical Examiner | 20b. Place of Disposition (Name of cemetery, crematory or other place) Greenmount Crematory | | 20c. Date December 22, 1997 | | 20d. Location - City or Town, State Baltimore, Maryland | | 21. Signature of Funeral Service Licensee Carlton R. Douglas | |
| | 22. Name and Address of Facility Douglas Funeral Service | | 22b. Date 12/22/97 | | 22c. Location - City or Town, State Baltimore, MD | | 22d. Zip Code 21217 | |
| To Be Completed by Physician/Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. CONGESTIVE CARDIOVASCULAR PATHY Due to (or as a consequence of): Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | | | | | | Approximate Interval Between Onset and Death |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CHRONIC RENAL FAILURE | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 <input checked="" type="checkbox"/> Unknown | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No |
| | 24a. Was an autopsy performed? 1 Yes 2 <input checked="" type="checkbox"/> No | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner? 1 Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 Yes 2 No | |
| To Be Completed by Physician/Medical Examiner | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 29d. Date signed (Month, Day, Year) DECEMBER 18, 97 | |
| | 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier K.S. RAO, M.D. | | 29c. License number 043462 | | | |
| To Be Completed by Physician/Medical Examiner | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) K.S. RAO, M.D. | | | | | | | |
| | 31. Date filed (Month, Day, Year) DEC 20 1997 | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 32. Registrar's Signature John Davidson-Randall | | | | | | | |
| | 33. Name and address of person who completed cause of death (Item 23a) (Type, Print) NORTHWEST HOSPITAL CENTER RANDALLSTOWN, MD | | | | | | | |

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38522

| | | | | | | | | |
|---|--|--|--|--|---|--|---|--|
| Physician /Medical Examiner | 1. Decedant's Name (First, Middle, Last) LAWRENCE D. ALEXANDER | | | | 2. Date of Death Month DECEMBER Day 18 Year 1997 | | 3. Time of Death 3:32 P.M. | |
| | 4e. Facility Name (If not institution, give street and number) Liberty Medical Center | | | | 4b. City, Town, or Location of Death Baltimore | | 4c. County of Death NA | |
| Funeral Director | 5. Social Security Number 231-18-5280 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 66 Yrs. | | 8. Date of Birth (Month, Day, Year) 2-10-1931 | |
| | 9. Birthplace (State or Foreign Country) Va | | 10a. State MD | | 10b. County NA | | 10c. City, Town or Location Baltimore | |
| To Be Completed by Funeral Director | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | 10e. Street and Number 5202 Beaufort | | 10f. Zip Code 21215 | |
| | 10g. Citizen of What Country? U.S.A | | | | 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | |
| To Be Completed by Physician/Medical Examiner | 13. Was Decedent of Hispanic Origin? (Specify Yes or No) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: Black | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10th grade College (14 or 5+) NA | |
| | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Welder | | | | 16b. Kind of Business/Industry Bethlehem Steel | | | |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last) Johnny Alexander | | | | 18. Mother's Name (First, Middle, Maiden Surname) Helen Edmondson | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Mary L. Alexander | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5202 Beaufort Avenue Baltimore, MD 21215 | | | |
| To Be Completed by Physician/Medical Examiner | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Garrison Forest Vet | | 20c. Location - City or Town, State 12-2397 Owings Mills, MD | |
| | 21. Signature of Funeral Service Licensee Bladys Wanner | | | | 22. Name and Address of Facility March F.H. West 4300 Wabash Avenue Baltimore, MD 21215 | | | |
| To Be Completed by Physician/Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) SEPSIS WITH HEPATIC ENCEPHALOPATHY Due to (or as a consequence of): CIRRHOSIS LIVER Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last HEPATO-RENAL SYNDROME WITH COAGULOPATHY Due to (or as a consequence of): UNKNOWN | | | | Approximate Interval Between Onset and Death 5 days | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CHRONIC OBSTRUCTIVE LUNG DISEASE ALCOHOL ABUSE. | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | |
| To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| To Be Completed by Physician/Medical Examiner | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicida <input type="checkbox"/> Homicida <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | |
| | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 28d. Describe how injury occurred | | | |
| To Be Completed by Physician/Medical Examiner | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. Signature and title of certifier SADHAR M.D. | | | |
| To Be Completed by Physician/Medical Examiner | 29c. License number D 23300 | | | | 29d. Date signed (Month, Day, Year) DECEMBER 18 1997 | | | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SUDHIR D. PATEL 2600 Liberty Heights, BALTO. MD. 21215 | | | | 31. Date (Month, Day, Year) DEC 22 1997 | | | |
| To Be Completed by Physician/Medical Examiner | 32. Registrar's Signature John Davidson-Randall | | | | 33. Registrar's Signature | | | |
| | 34. Registrar's Signature | | | | 35. Registrar's Signature | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38523

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Edward

ADAMS

2. Date of Death

Month Day Year
December 21, 1997

3. Time of Death

10:55 AM

4a. Facility Name (If not institution, give street and number)

Franklin Square Hospital Center

4b. City, Town, or Location of Death

Rosedale

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

212-40-3933

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

55 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
April 30, 1942

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Essex

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

852 Middlesex Road

10f. Zip Code

21221

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: 1961-6413. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

10

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working
life. DO NOT use retired)

Manager

16b. Kind of Business/Industry

Grocery Store

17. Father's Name (First, Middle, Last)

Edward G. Adams

18. Mother's Name (First, Middle, Maiden Surname)

Edna Merritt

19a. Informant's Name/Relationship (Type, Print)

Ellen Adams (WIFE)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

852 Middlesex Road Essex, Md. 21221

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Holly Hill Mem. Gardens 12/23/1997

Date

20c. Location - City or Town, State

Baltimore, Co., Md.

21. Signature of Funeral Service Licensed

22. Name and Address of Facility

Bruzdzinski Funeral Home P.A.

1407 Old Eastern Avenue Essex, Md. 21221

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. End Stage Small Cell Lung Cancer

21 Months

Due to (or as a consequence of):

b. Metastatic Disease

Due to (or as a consequence of):

c. Diabetes

Due to (or as a consequence of):

d. History of Cerebrovascular Accident

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) LastApproximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home5 ☐ Residence8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
2 ☐ Accident investigation
3 ☐ Suicide 6 ☐ Could not be
4 ☐ Homicide determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

29c. License number

RD# 02341

29d. Date signed (Month, Day, Year)

12/21/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Thomas Lee MD. 9000 Franklin Square Dr. Balto, Md. 21237

31. Date (Month, Day, Year)

DEC 22 1997

32. Registrar's Signature
John Davidson-RosdaleState
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

1541

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38524

| | | | | | | | | |
|---|---|--|--|--|--|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Herman A. Austin | | | | 2. Date of Death Month Day Year Dec. 15, 1997 | | 3. Time of Death 5:30am | |
| | 4a. Facility Name (If not institution, give street and number) 8310 Autumn Way #1B | | | | 4b. City, Town, or Location of Death Jessup | | 4c. County of Death Howard | |
| Funeral Director | 5. Social Security Number 116-22-9193 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 75 Yrs. | | 8. Date of Birth (Month, Day, Year) Sept 23, 1922 | |
| | 9. Birthplace (State or Foreign Country) New Jersey | | 10a. State MD. | | 10b. County Howard | | 10c. City, Town or Location Jessup | |
| To Be Completed by Funeral Director | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 10e. Street and Number 8310 Autumn Way #1B | | 10f. Zip Code 20794 | |
| | 10g. Citizen of What Country? U.S.A. | | | | 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: WWII | |
| To Be Completed by Physician/Medical Examiner | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: Black | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7 College (1-4 or 5+) attorney | |
| | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) law | | | | 16b. Kind of Business/Industry law | | 17. Father's Name (First, Middle, Last) Leon Alston | |
| To Be Completed by Physician/Medical Examiner | 18. Mother's Name (First, Middle, Maiden Surname) Miriam Washington | | | | 19a. Informant's Name/Relationship (Type, Print) Lillian C. Austin, wife | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8310 Autumn Way #1B, Jessup, Md. 20794 | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Long Island National Cem. 12/19/97 | | 20c. Location - City or Town, State Long Island Suffolk Co., N.Y. | |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee Thanda L Lemmer | | | | 22. Name and Address of Facility Witzke Funeral Home, Inc. 5555 Twin Knolls Rd., Columbia, Md. 21045 | | | |
| | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Congestive Cardiac Failure Atherosclerotic Cardiovascular Disease | | | | Approximate Interval Between Onset and Death 1 year | | | |
| To Be Completed by Physician/Medical Examiner | 23b. Part 2. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. End Stage Renal Disease Hypertension | | | | 23c. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | |
| | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day Year) M | | | |
| To Be Completed by Physician/Medical Examiner | 28b. Time of Injury M | | | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| | 28d. Describe how injury occurred | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | |
| To Be Completed by Physician/Medical Examiner | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| | 29b. Signature and title of certifier Nasim Ashraf MD | | | | 29c. License number D0052161 | | | |
| To Be Completed by Physician/Medical Examiner | 29d. Date signed (Month, Day, Year) 12.15.97 | | | | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) NASIM ASHRAF MD | | | |
| | 31. Date filed (Month, Day, Year) DEC 22 1997 | | | | 32. Registrar's Signature John Davidson-Randall | | | |

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the funeral-transit certificate.

1890

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1899

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State of Maryland / Department of Health and Mental Hygiene 97 38525

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Derek Ash

2. Date of Death

Month Day Year
December 17 1997

3. Time of Death

5:10 AM

4a. Facility Name (If not institution, give street and number)

University of Maryland

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

W. A

Funeral
Director

5. Social Security Number

214 441998

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

52 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
3/5/45

9. Birthplace (State or Foreign Country)

A. D

Usual Residence of Decedent

10a. State

MD

10b. County

N. A.

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1504 E. Lafayette AVE

10f. Zip Code

21213

10g. Citizen of What Country?

U. S. A

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8th

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Technician

16b. Kind of Business/Industry

Air Condition Co

17. Father's Name (First, Middle, Last)

John Ash

18. Mother's Name (First, Middle, Maiden Surname)

Susan Squire

19a. Informant's Name/Relationship (Type, Print)

Angela Ash

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1504 E. Lafayette Ave Balto-Md 21213

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Anteburial Home PH 12/22/97

Date

20c. Location - City or Town, State

Anteburial Md

21. Signature of Funeral Service Licensee

Joseph B. Locke

22. Name and Address of Facility

Locke Funeral Home

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. acute respiratory distress syndrome

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. sepsis

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ESRD

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Joseph B. Locke

29c. License number

P10248

29d. Date signed (Month, Day, Year)

December 17 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Joseph Regan 22 S. Greens St. Baltimore, MD

31. Date filed (Month, Day, Year)

DEC 22 1997

32. Registrar's Signature

Julia Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38526

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician
/Medical
ExaminerFuneral
Director

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. Decedent's Name (First, Middle, Last) Robert Joseph Augustyniak | | | | 2. Date of Death Month DEC. Day 15 Year 1997 | | 3. Time of Death 0813 AM | |
| 4a. Facility Name (If not institution, give street and number) BEL AIR ROAD & OLD FORGE ROAD | | | | 4b. City, Town, or Location of Death Baltimore | | 4c. County of Death BAITMORE | |
| 5. Social Security Number 220-98-5991 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 26 Yrs. | | 8. Date of Birth (Month, Day, Year) Jan. 4, 1971 | |
| 9. Birthplace (State or Foreign Country) Baltimore, Maryland | | 10a. State Maryland | | 10b. County Baltimore | | 10c. City, Town or Location Baltimore | |
| 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number 8007 Blair Road | | 10f. Zip Code 21236 | | 10g. Citizen of What Country? U.S.A. | |
| 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th. | | 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Fulltime Student | | 16b. Kind of Business/Industry University of Baltimore Law School | | | |
| 17. Father's Name (First, Middle, Last) John Francis Augustyniak | | | | 18. Mother's Name (First, Middle, Maiden Summa) Jean Evelyn Durham | | | |
| 19a. Informant's Name/Relationship (Type, Print) John F. Augustyniak (Father) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5822 Stevens Rd. White Marsh, Md. 21162 | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Holy Hill Cemetery | | Date 12/19/97 | | 20c. Location - City or Town, State Baltimore, Maryland | |
| 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility E. F. Lassahn Funeral Home 11750 Belair Rd. Kingsville, Md. 21087 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Multiple Injuries Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | |
| 24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) ROADWAY | | | | | |
| 27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) 12-15-97 | | 28b. Time of injury 0845M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 28d. Describe how injury occurred Driver Auto Auto collision | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Roadway | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) Bel Air Rd | | | |
| 29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier | | 29c. License number O.C.M.E | | 29d. Date signed (Month, Day, Year) DEC. 15, 1997 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) David R Fowler 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 22 1997 | | 32. Registrar's Signature | | | | | |

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 38527

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

Norman L. Ayres SR.

2. Date of Death

Month
12Day
15Year
97

3. Time of Death

11:15

4a. Facility Name (If not institution, give street and number)

umms

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Baltimore City

5. Social Security Number

219-30-0909

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

63

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

January 1, 1934

9. Birthplace (State or Foreign Country)

Bradshaw, Md.

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

White Marsh

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

5816 Affeld Ave.

10f. Zip Code

21162

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever In U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.
Specify: White15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
5th.College (1-4 or 5+)
n/a18a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Mechanic

16b. Kind of Business/Industry

Knight Trucking

17. Father's Name (First, Middle, Last)

Norman Oscar Ayres

18. Mother's Name (First, Middle, Maiden Surname)

Pearl Beatrice Knight

19a. Informant's Name/Relationship (Type, Print) (Daughter
Mrs. Sandra K. Ayres In-Law)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11035 Pulaski Highway White Marsh, Maryland 21162

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

BelAir Memorial Gardens 12/20/97 BelAir, Maryland

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

E. F. Lassahn

22. Name and Address of Facility

E. F. Lassahn Funeral Home
11750 Belair Road Kingsville, Md. 2108723a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)a. Myocardial Infarction
Due to (or as a consequence of):Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Lastb. Coronary Artery D2
Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes

Hypertension

Hypercholesterolemia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Wade Paasch, MD

29c. License number

D37818

29d. Date signed (Month, Day, Year)

12/15/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

umms ED

State
Registrar

31. Date filed (Month, Day, Year)

DEC 22 1997

32. Registrar's Signature

John Davidson-Randall

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be completed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38528

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Barbara M. Boteler

2. Date of Death

Month
Dec.Day
18Year
1997

3. Time of Death

10:00 P.M.

4a. Facility Name (If not institution, give street and number)

1627 Lorimer Road

4b. City, Town, or Location of Death

Glen Burnie

4c. County of Death

Anne Arundel

5. Social Security Number

213-74-0708

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

99

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

March 13, 1898

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

n/a

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1911 W. Lombard Street

10f. Zip Code

21223

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No
if Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

homemaker

16b. Kind of Business/Industry

home

17. Father's Name (First, Middle, Last)

John M. Luskorn

18. Mother's Name (First, Middle, Maiden Surname)

Susan Winkler

19a. Informant's Name/Relationship (Type, Print)

Agnes Gover - daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1627 Lorimer Road, Glen Burnie, MD 21061

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Baltimore National Cemet. 12/22/97 Baltimore, MD

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Anthony S. Dimm

22. Name and Address of Facility

Loudon Park Funeral Home
3620 Wilkens Avenue
Baltimore, MD 2122923a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

e.

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Approximate
Interval Between
Onset and Death

< 1d

10 yr

10 yr.

15 yrs

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ NoHospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of injury

(Month, Day Year)

28b. Time of
injury

M

28c. Injury et
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)29. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Anthony S. Dimm physician

29c. License number

D 29769

29d. Date signed (Month, Day, Year)

12/19/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Marcelino D. Albuverne MD 516 W. Rolling Rd Balt. Md

31. Date filed (Month, Day, Year)

DEC 22 1997

32. Registrar's Signature

John Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38529

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Mildred Blume

2. Date of Death

December 18 1997

3. Time of Death

6:25 PM

4e. Facility Name (If not institution, give street and number)

Mercy Medical center

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Funeral
Director

5. Social Security Number

213-01-0382D

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

92

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

11-25-1905

9. Birthplace (State or Foreign Country)

Baltimore, MD

Usual Residence of Decedent

10a. State

Md.

10b. County

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3904 Mt. Pleasant Avenue

10f. Zip Code

21224

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced12. Was Decedent Ever in U.S.
Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.
Specify: White15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
4th

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

In own Home

17. Father's Name (First, Middle, Last)

Adolph Mardaga

18. Mother's Name (First, Middle, Maiden Surname)

Josephine White

19a. Informant's Name/Relationship (Type, Print) daughter
Sister Alma Blume19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3904 Mt. Pleasant Ave., Baltimore, Maryland 21224

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Holy Redeemer Cemetery

Date

12/22/97

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Maria S. Zannino

22. Name and Address of Facility

Joseph N. Zannino Jr. Funeral Home
263 S. Conkling St. Baltimore, Maryland 2122423a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)a. Cardiogenic shock
Due to (or as a consequence of):b. Aortic stenosis
Due to (or as a consequence of):c.
Due to (or as a consequence of):d.
Due to (or as a consequence of):Approximate
Interval Between
Onset and Death1 day
20 years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Congestive Heart Failure
Diabetes Mellitus.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation
6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Vijay Pethkar M.D.

29c. License number

D 50853

29d. Date signed (Month, Day, Year)

December 18, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Vijay Pethkar 307 St. Paul Place Baltimore MD 21202.

31. Date filed (Month, Day, Year)

DEC 22 1997

32. Registrar's Signature

John Davidson-Pandele

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760.

To the Hospital or Attending Physician: The law requires that the death certificate be completed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38530

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

MARIA BIRSA

2. Date of Death

Month
12Day
17Year
97

3. Time of Death

8:45 pm

4a. Facility Name (If not institution, give street and number)

Cromwell Center

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Baltimore County

Funeral
Director

5. Social Security Number

214-34-3645

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

96

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

Month Day Year

August 17, 1901

9. Birthplace (State or Foreign Country)

Italy

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George

10c. City, Town or Location

Laurel

10d. Inside City Limits

1 ☐ Yes ☒ No

10e. Street and Number

11806 Montague Drive

10f. Zip Code

20708

10g. Citizen of What Country?

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

10

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

homemaker

16b. Kind of Business/Industry

at home

17. Father's Name (First, Middle, Last)

Joseph Birsas

18. Mother's Name (First, Middle, Maiden Surname)

Maria Volk

19a. Informant's Name/Relationship (Type, Print)

Mr. Frank Birsas/son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11806 Montague Drive, Laurel, Maryland 20708

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

New Cathedral Cemetery

Date

20DEC97

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

M00535

22. Name and Address of Facility

Slack Funeral Home, P.A.

Ellicott City, Maryland 21043

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a.

CORONARY ARTERY DISEASE

Due to (or as a consequence of):

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

HYPERTENSION

CONGESTIVE HEART FAILURE

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D47945

29d. Date signed (Month, Day, Year)

12/19/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Hais Aleem 3007 E. Northern Parkway BA. MD 21214

31. Date filed (Month, Day, Year)

DEC 22 1997

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38531

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Wen Yan Cao

2. Date of Death

Month Day Year
Dec. 16, 1997

3. Time of Death

3:30AM

4a. Facility Name (If not institution, give street and number)

The Johns Hopkins HOSPITAL

4b. City, Town, or Location of Death

Baltimore City

4c. County of Death

N/A

5. Social Security Number

231-37-3373

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

40

Yrs.

8. Date of Birth

Month Day Year
May. 10, 1957

9. Birthplace (State or Foreign Country)

China

Usual Residence of Decedent

10a. State

Virginia

10b. County

Fairfax

10c. City, Town or Location

Springfield

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7202 Hidden Ridge Court

10f. Zip Code

22152

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Oriental

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Manager

16b. Kind of Business/Industry

Restaurant

17. Father's Name (First, Middle, Last)

Jian Cao

18. Mother's Name (First, Middle, Maiden Surname)

Yu Rong Wu

19a. Informant's Name/Relationship (Type, Print)

Louis Hutchinson (Husband)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7202 Hidden Ridge Ct., Springfield, Va. 22152

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Fairfax Memorial Park

Date

12/20/97

20c. Location - City or Town, State

Fairfax, Virginia

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Everly Colonial Funeral Home

6161 Leesburg Pike, Falls Church, Va. 22044

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Acute lymphocytic leukemia

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

8 months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Bone marrow transplantation

Due to (or as a consequence of):

40 days

c. Liver failure

Due to (or as a consequence of):

11 days

d. Multisystem organ system failure

11 days

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

29b. Signature and title of certifier

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

December 16, 1997

30. Name and address of person who completed cause of death (item 23e) (Type, Print)

Christopher G. Hall M.D. Johns Hopkins Hospital, Tower #110 Baltimore

31. Date filed (Month, Day, Year)

DEC 22 1997

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

97-7275-510

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

ESTELLE
CORPREW

State of Maryland / Department of Health and Mental Hygiene

Items: 23 part I, 27, 28a-f per MEO G-755 1/2 ^{reb.} Certificate of Death

Reg. No. 97 38532

Physician
/Medical
ExaminerFuneral
Director

| | | | | | |
|--|--|--|--|---|--|
| 1. Decedent's Name (First, Middle, Last) Estelle Corprew | | 2. Date of Death Month Day Year DECEMBER 17, 1997 | | 3. Time of Death 4:43 P.M. | |
| 4a. Facility Name (If not institution, give street and number) 257 N. BRUCE STREET | | 4b. City, Town, or Location of Death BALTIMORE | | 4c. County of Death N/A | |
| 5. Social Security Number 215-86-8247 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 31 Yrs. | |
| 8. Date of Birth (Month, Day, Year) 6 26 1966 | | 9. Birthplace (State or Foreign Country) Maryland | | | |
| 10a. State Maryland | | 10b. County N/A | | 10c. City, Town or Location Baltimore | |
| 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number 526 N. Mount Street | | 10f. Zip Code 21223 | |
| 10g. Citizen of What Country? USA | | 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | |
| 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Black | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4or 5+) N/A | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Custodian | | 16b. Kind of Business/Industry Food | |
| 17. Father's Name (First, Middle, Last) Chester Wyman | | 18. Mother's Name (First, Middle, Maiden Surname) Estelle Corprew | | | |
| 19a. Informant's Name/Relationship (Type, Print) Estelle Corprew-Mother | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 526 N. Mount St. BALTO. MD 21223 | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) MT. Zion Cemetery | | 20c. Location - City or Town, State 12-23-97 Landsdowne | |
| 21. Signature of Funeral Service Licensee Joseph R. Walters Jr. | | 22. Name and Address of Facility Unity Funeral Home BALTO. MD. 21201 | | | |
| 23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) NARCOTIC INTOXICATION Due to (or as a consequence of): Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): | | Approximate Interval Between Onset and Death | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| | | | | 24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) FRIENDS HOUSE | | | |
| 27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) 12/17/97 found | | 28b. Time of Injury 4:30 M | |
| 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred Subject ingested drugs | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) 257 N. Bruce St. Baltimore, Md. | |
| 29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) as stated. | | 29b. Signature and title of certifier Anthony A. Madz, MD | | 29c. License number O.C.M.E. | |
| 29d. Date signed (Month, Day, Year) DECEMBER 18, 1997 | | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Stephen Radentz, M.D. 111 Penn Street, Baltimore, Maryland 21201 | | | |
| 31. Date filed (Month, Day, Year) DEC 22 1997 | | 32. Signature of Registrar John Radentz | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38533

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

THOMAS

CLECKNER

2. Date of Death

Month

Day

Year

December 19 1997

3. Time of Death

11:05 AM

4a. Facility Name (If not institution, give street and number)

Good Samaritan Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

217-24-0682

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

69

If Under 1 Year

Months

If Under 24 Hrs.

Days

Hours

Min.

8. Date of Birth

(Month, Day, Year)

April 10, 1928

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Essex

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

2021 New Haven Drive

10f. Zip Code

21221

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☒ Married

☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

3

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Interior Decorator

16b. Kind of Business/Industry

Interior Design

17. Father's Name (First, Middle, Last)

John Coyle Cleckner

18. Mother's Name (First, Middle, Maiden Surname)

Margaret Mary Dunn

19a. Informant's Name/Relationship (Type, Print)

JoAnn Patricia Cleckner (WIFE)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2021 New Haven Drive Baltimore, Md. 21221

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State

☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Greenmount Crematory 12/23/1997

Date

20c. Location - City or Town, State

Baltimore, Md.

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

Bruzdziński Funeral Home P.A.

1407 Old Eastern Avenue Essex, Md. 21221

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Sepsis.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☒ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☒ Inpatient

☐ ER/Outpatient

☐ DOA

Other:

☐ Nursing Home

☐ Residence

☐ Other (Specify)

27. Manner of Death

☒ Natural

☐ Accident

☐ Suicide

☐ Homicide

☐ Pending investigation

☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Adriana Andrade, MD

29c. License number

P10579

29d. Date signed (Month, Day, Year)

December 19, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Good Samaritan Hospital 5601 Loch Raven Boulevard

Baltimore, Maryland 21239-2995

31. Date filed (Month, Day, Year)

DEC 22 1997

[Signature]

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 38534

Certificate of Death

Reg. No.

| | | | | | |
|--|--|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) JAMES COLES | | 2. Date of Death Month Day Year DECEMBER 16 1997 | | 3. Time of Death 17:10 |
| | 4a. Facility Name (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL | | 4b. City, Town, or Location of Death BALTIMORE CITY | | 4c. County of Death |
| Funeral Director | 5. Social Security Number 229-28-9606 | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 66 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. |
| | 8. Date of Birth (Month, Day, Year) May 31, 1931 | | 9. Birthplace (State or Foreign Country) Virginia | | |
| To Be Completed by Funeral Director | Usual Residence of Decedent | | 10e. State MD | | 10b. County Baltimore |
| | 10c. City, Town or Location Baltimore | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | 10e. Street and Number 4320 Clareway Apt 3-T | | 10f. Zip Code 21213 | | 10g. Citizen of What Country? USA |
| | 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
| | 14. Race - American Indian, Black, White, etc. Specify: Black | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 2 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Computer Operator |
| | 16b. Kind of Business/Industry unknown | | 17. Father's Name (First, Middle, Last) unknown | | 18. Mother's Name (First, Middle, Maiden Surname) Hattie Coles |
| | 19e. Informant's Name/Relationship (Type, Print) Carol Hill Jones/daughter | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1546 Treehaven Drive, Richmond, Virginia 23224 | | |
| | 20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Evergreen Cemetery | | 20c. Location - City or Town, State Richmond, Virginia |
| | 21. Signature of Funeral Service Licentiate | | 22. Name and Address of Facility Donaldson Funeral Home, P.A. 313 Talbott Ave. Laurel, Maryland 20707-4389 | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. PNEUMONIA Due to (or as a consequence of): b. ACQUIRED IMMUNE DEFICIENCY SYNDROME Due to (or as a consequence of): c. DIABETES MELLITUS Due to (or as a consequence of): d. | | Approximate Interval Between Onset and Death THREE WEEKS THREE MONTHS TEN YEARS | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DIABETIC FOOT ULCER NEW ONSET SEIZURES | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28e. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28d. Describe how injury occurred | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier ► Lawrence MD MEDICINE INTERN | | 29c. License number 05617 | 29d. Date signed (Month, Day, Year) DECEMBER 16, 1997 |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) MARILYN LAWRENCE, JOHNS HOPKINS HOSPITAL, 600 NORTH WOLFE STREET, BALTIMORE, MARYLAND 21287 | | 31. Date filed (Month, Day, Year) DEC 22 1997 | | | |
| 32. Registrar's Signature | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38535

| | | | | | | | | |
|--|---|---|--|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) LEO T. CARTY | | | | 2. Date of Death Month December Day 13 Year 1997 | | 3. Time of Death 8:45 PM | |
| | 4a. Facility Name (If not institution, give street and number) Laurel Regional Hospital | | | | 4b. City, Town, or Location of Death Laurel | | 4c. County of Death Prince George | |
| Funeral Director | 5. Social Security Number 050-26-4507 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 65 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) Oct. 11, 1932 | 9. Birthplace (State or Foreign Country) Massachusetts |
| | Usual Residence of Decedent | | | | 10c. City, Town or Location Laurel | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10a. State MD | | 10b. County Prince George | | 10e. Street and Number 8825 Briarcroft Lane | | 10f. Zip Code 20708 | | 10g. Citizen of What Country? USA |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 | | College (1-4 or 5+) 4 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Classified | | 16b. Kind of Business/Industry Dept. of Defense | | |
| 17. Father's Name (First, Middle, Last) Thomas Leo Carty | | | | 18. Mother's Name (First, Middle, Maiden Surname) Mary A. Trainor | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Betty R. Carty/Wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8825 Briarcroft Lane, Laurel, Maryland 20708 | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Ivy Hill Cemetery | | Date 12/17 | | 20c. Location - City or Town, State Laurel, Maryland |
| 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility Fleck Funeral Home, Inc. 7601 Sandy Spring Road, Laurel, Maryland 20707 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Atrial Fibrillation Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | | | Approximate Interval Between Onset and Death One Year | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier Andrew Kunda MD | | 29c. License number 036716 | | 29d. Date signed (Month, Day, Year) December 15, 1997 | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Andrew Kunda, M.D. 8317 Cherry Lane, Laurel, Md 20707 | | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 22 1997 | | | | 32. Registrar's Signature | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or items 23a or 24a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

38536

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be completed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | | |
|--|--|---|--------------------------------|---|---|
| 1. Decedent's Name (First, Middle, Last) Elsie Draper | | 2. Date of Death Month Dec Day 17 Year 97 | | 3. Time of Death 9:15 PM | |
| 4a. Facility Name (If not institution, give street and number) Bon Secours Hospital | | 4b. City, Town, or Location of Death Baltimore | | 4c. County of Death NA | |
| 5. Social Security Number 212-82-8181 | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) 4-14-1919 |
| 9. Birthplace (State or Foreign Country) MD | | 10. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| 10a. State MD | 10b. County NA | 10c. City, Town or Location Baltimore | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10e. Street and Number 2601 Roslyn Avenue | | 10f. Zip Code 21216 | | 10g. Citizen of What Country? U.S.A | |
| 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | |
| 14. Race - American Indian, Black, White, etc. Specify: | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th grade College (1-4 or 5+) NA | | | |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Disabled | | 16b. Kind of Business/Industry NA | | | |
| 17. Father's Name (First, Middle, Last) Andrew J. Draper | | 18. Mother's Name (First, Middle, Maiden Surname) Anniebell | | | |
| 19a. Informant's Name/Relationship (Type, Print) Dr. Edgar D. Draper - Brother | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2728 Longwood Street Balto, Md 21218 | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) King Memorial Park | | 20c. Location - City or Town, State 12-22-97 Randallstown, Md | |
| 21. Signature of Funeral Service Licensee Richard W. Wane | | 22. Name and Address of Facility March F. H. Wast 4300 Wabash Avenue Balto, Md 21215 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Carcinoma of the duodenum Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | Approximate Interval Between Onset and Death | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | |
| 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | |
| 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | | |
| 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | |
| 29b. Signature and title of certifier [Signature] | | 29c. License number D18327 | | 29d. Date signed (Month, Day, Year) Dec 22, 97 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Moges Sebremanian 4660 Wilkens Ave # 203 Balto Md 21229 | | | | | |
| 31. Date filed (Month, Day, Year) DEC 22 1997 | | 32. Registrar's Signature [Signature] | | | |

State Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 38537

Certificate of Death

Reg. No.

| | | | | | | | | | | |
|---|---|---|--|---|--|--|--------------------------------|---|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Earl C Dubois | | | | 2. Date of Death Month December Day 19 Year 1997 | | | | 3. Time of Death 10 00 PM | |
| | 4e. Facility Name (If not institution, give street and number) Sinai Hospital | | | | 4b. City, Town, or Location of Death Baltimore | | | | 4c. County of Death N/A | |
| Funeral Director | 5. Social Security Number 219-03-5730 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 85 Yrs. | | If Under 1 Year Months Days | | If Under 24 Hrs. Hours Min. | |
| | 8. Date of Birth (Month, Day, Year) Aug 10, 1912 | | 9. Birthplace (State or Foreign Country) Maryland | | 10a. State Maryland | | 10b. County N/A | | 10c. City, Town or Location Baltimore | |
| Usual Residence of Decedent | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number 2039 Druid Park Drive | | 10f. Zip Code 21211 | | 10g. Citizen of What Country? U.S.A | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4or 5+) | | |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Milkman | | 16b. Kind of Business/Industry Sealtest Dairy | | 17. Father's Name (First, Middle, Last) unk | | 18. Mother's Name (First, Middle, Maiden Surname) unk | | 19a. Informant's Name/Relationship (Type, Print) Claudette Peddicord (Daughter) | | |
| 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2039 Druid Park Drive, Baltimore, Maryland 21211 | | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) New Cathedral Cemetery | | 20c. Date 12/23/97 | | 20d. Location - City or Town, State Baltimore, Maryland | | |
| 21. Signature of Funeral Service Licensee A. Alan Seitz, Jr. | | 22. Name and Address of Facility A. Alan Seitz, Jr. Funeral Home 3818 Roland Avenue, Baltimore, Maryland 21211 | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Pneumonia | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | 23c. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 23d. Immediate Cause (Final disease or condition resulting in death) Malnutrition | | 23e. Due to (or as a consequence of): | | 23f. Due to (or as a consequence of): | | 23g. Due to (or as a consequence of): | | 23h. Due to (or as a consequence of): | | |
| 23i. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | 23j. Due to (or as a consequence of): | | 23k. Due to (or as a consequence of): | | 23l. Due to (or as a consequence of): | | 23m. Due to (or as a consequence of): | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | 24a. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier Erik DeLue MD | | 29c. License number AS 2402321 ED 9346 | | |
| 29d. Date signed (Month, Day, Year) December 19, 1997 | | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Erik DeLue Sinai Hospital | | 31. Date filed (Month, Day, Year) DEC 22 1997 | | 32. Registrar's Signature Julia Davidson-Randall | | 33. State Registrar | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23e show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 38538

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

LEO A. DICUS

2. Date of Death

Month Day Year
DECEMBER 16 97 02:20

3. Time of Death

Funeral
Director

4a. Facility Name (If not institution, give street and number)

ST. AGNES HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

5. Social Security Number

218-62-9588

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

44

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

OCT. 25, 1953

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State
MARYLAND

10b. County

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2022 WILKENS AVENUE

10f. Zip Code

21223

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

WHITE

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

Collage (1-4 or 5+)

12

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

SELF EMPLOYED CLOTHING VENDOR

16b. Kind of Business/Industry

STREET VENDOR

17. Father's Name (First, Middle, Last)

BERNARD DICUS

18. Mother's Name (First, Middle, Maiden Summa)

KATHLEEN BRYAN

19a. Informant's Name/Relationship (Type, Print)

BERNARD DICUS, BROTHER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1711 A STREET S.E., WASHINGTON D.C. 20003

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

ST. PAUL'S LUTHERAN CEM.

Date

12/20/97

20c. Location - City or Town, State

VIOLITVILLE, MARYLAND

21. Signature of Funeral Service Licensee

► Sandra L Lemmer

22. Name and Address of Facility

WITZKE FUNERAL HOMES, INC.

1630 EDMONDSON AVENUE, CATONSVILLE, MD 21228

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a.

HEPATIC ENCEPHALOPATHY

3 mo

Due to (or as a consequence of):

b.

HEPATO-RENAL SYNDROME

2 weeks

Due to (or as a consequence of):

c.

CIRRHOSIS

3 years

Due to (or as a consequence of):

d.

VIRAL HEPATITIS A, B, C

5 years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

► [Signature] M.D.

29c. License number

P11701

29d. Date signed (Month, Day, Year)

DECEMBER 16, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NICULESCU I. FLORIN, ST. AGNES HOSP. 900 CATON AVE.

31. Date filed (Month, Day, Year)

DEC 22 1997

32. Registrar's Signature

Julia Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

NAME: DICUS LEO A.
Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be completed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38539

| | | | | | | | | |
|--|--|---|--|--|--|--|--|---|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) ANNA DAWSON | | | | 2. Date of Death Month DECEMBER Day 21 Year 1997 | | 3. Time of Death 4:40 AM | |
| | 4a. Facility Name (If not institution, give street and number) Saint Joseph Medical Center | | | | 4b. City, Town, or Location of Death Towson | | 4c. County of Death Baltimore | |
| Funeral Director | 5. Social Security Number 291-05-9188 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 99 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) FEB. 11 1898 | 9. Birthplace (State or Foreign Country) Pennsylvania |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State MD. | | 10b. County Baltimore | | 10c. City, Town or Location Towson | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 10e. Street and Number 104 Kenilworth Park Drive #2C | | | | 10f. Zip Code 21204 | | 10g. Citizen of What Country? USA | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker | | 16b. Kind of Business/Industry Own Home | | |
| 17. Father's Name (First, Middle, Last) Joseph H. Boorem | | | | 18. Mother's Name (First, Middle, Maiden Surname) Celeste Christman | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Mr. W. Lee Thomas/Nephew | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1106 Sleepy Dell Ct. Towson, MD. 21286 | | | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Hilltop Service Co. | | Date 12-22-97 | | 20c. Location - City or Town, State Towson, MD. | | |
| 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, MD. 21204 | | | | |
| 23a. Pertinent disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. CONGESTIVE HEART FAILURE Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CHRONIC RENAL FAILURE HYPERTENSIVE CARDIOVASCULAR DISEASE | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 28d. Describe how injury occurred | | | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier | | | | 29c. License number D37254 | | 29d. Date signed (Month, Day, Year) 12/21/97 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BOON P. LIM, M.D., 7620 YORK ROAD, TOWSON, MARYLAND 21204 | | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 22 1997 | | | | 32. Registrar's Signature | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

RECEIVED

1964

1964

1964

1964

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Amended #1 per Phy G755 1/2/98 EW

Amended #5 per Informant G755 1/02/98 EW

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

38540

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

~~Dolores B. Dubose~~ Delores B. Dubose

2. Date of Death

Month

Day

Year

3. Time of Death

12 19 1997 2:45

4a. Facility Name (If not institution, give street and number)

2401 E. Northern PARKWAY

4b. City, Town, or Location of Death

Balt.

4c. County of Death

N. A

Funeral
Director

5. Social Security Number

~~916 215 34-4982~~

6. Sex

1 ☐ M 2 ☒ F

7. Age (in yrs. last birthday)

56 Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

8. Date of Birth

3/13/41

(Month, Day, Year)

9. Birthplace (State or Foreign Country)

Md.

Usual Residence of Decedent

10a. State

MD

10b. County

N. A

10c. City, Town or Location

Balt.

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2401 E Northern PKWY

10f. Zip Code

21214

10g. Citizen of What Country?

U.S.A

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever In U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12th

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

TECHNICIAN

16b. Kind of Business/Industry

So. Sec Adm.

17. Father's Name (First, Middle, Last)

LISLON BACON

18. Mother's Name (First, Middle, Maiden Surname)

MAUDELL MOODY

19a. Informant's Name/Relationship (Type, Print)

ELLA MAC. MYERS

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2401 E. Northern PKWY Balt. Md 21214

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

MT. CALVARY CEM

Date

12/27/97

20c. Location - City or Town, State

A.A. County. Md

21. Signature of Funeral Service Licensee

Joseph M. Locks

22. Name and Address of Facility

Locks Funeral Home 1304 N. Central Ave

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Lung cancer
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

8 months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes mellitus

Stroke

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Joseph M. Locks MD

29c. License number

D36131

29d. Date signed (Month, Day, Year)

Dec 19, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Suite 203, 7600 Osler Drive, Towson, MD 21204

31. Date filed (Month, Day, Year)

DEC 22 1997

John Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be completed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 38541

| | | | | | | | | |
|---|---|---|--|--|--|--|---|---|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Lucy B Freeland | | | | 2. Date of Death Month December Day 16 Year 1997 | | 3. Time of Death 10⁰⁵ PM | |
| | 4a. Facility Name (If not institution, give street and number) Wilson Health Care | | | | 4b. City, Town, or Location of Death Gaithersburg | | 4c. County of Death Montgomery | |
| Funeral Director | 5. Social Security Number 569-42-7735 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 93 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) December 13, 1904 | 9. Birthplace (State or Foreign Country) Pennsylvania |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State Maryland | | 10b. County Montgomery | | 10c. City, Town or Location Gaithersburg | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 10e. Street and Number 301 Russell Avenue | | | | 10f. Zip Code 20877 | | 10g. Citizen of What Country? U.S.A. | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Teacher | | 16b. Kind of Business/Industry Methodist Church | | |
| 17. Father's Name (First, Middle, Last) Clayton Bickel | | | | 18. Mother's Name (First, Middle, Maiden Surname) Mary Nitzsche Bickel | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Thomas H. Freeland, Stepson | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2612 Yarmouth Lane, Tallahassee, Florida 32308 | | | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Carroll Cremation | | Date 12-19-97 | | 20c. Location - City or Town, State Hampstead, Maryland | | |
| 21. Signature of Funeral Service Licensee R. Gray Withers | | | | 22. Name and Address of Facility Witzke Funeral Homes, Inc. 1630 Edmonson Avenue, Catonsville, MD 21228 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. Cerebral Arteriosclerosis Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death 7 years |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier James R. Moore Jr. MD | | | | | | |
| | | 29c. License number 07231 | | 29d. Date signed (Month, Day, Year) December 17, 1997 | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) James R. Moore Jr. 207 Brooker Ave Gaithersburg MD 20877 | | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 22 1997 | | 32. Registrar's Signature John Anderson | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38542

Physician
/Medical
Examiner

Funeral
Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

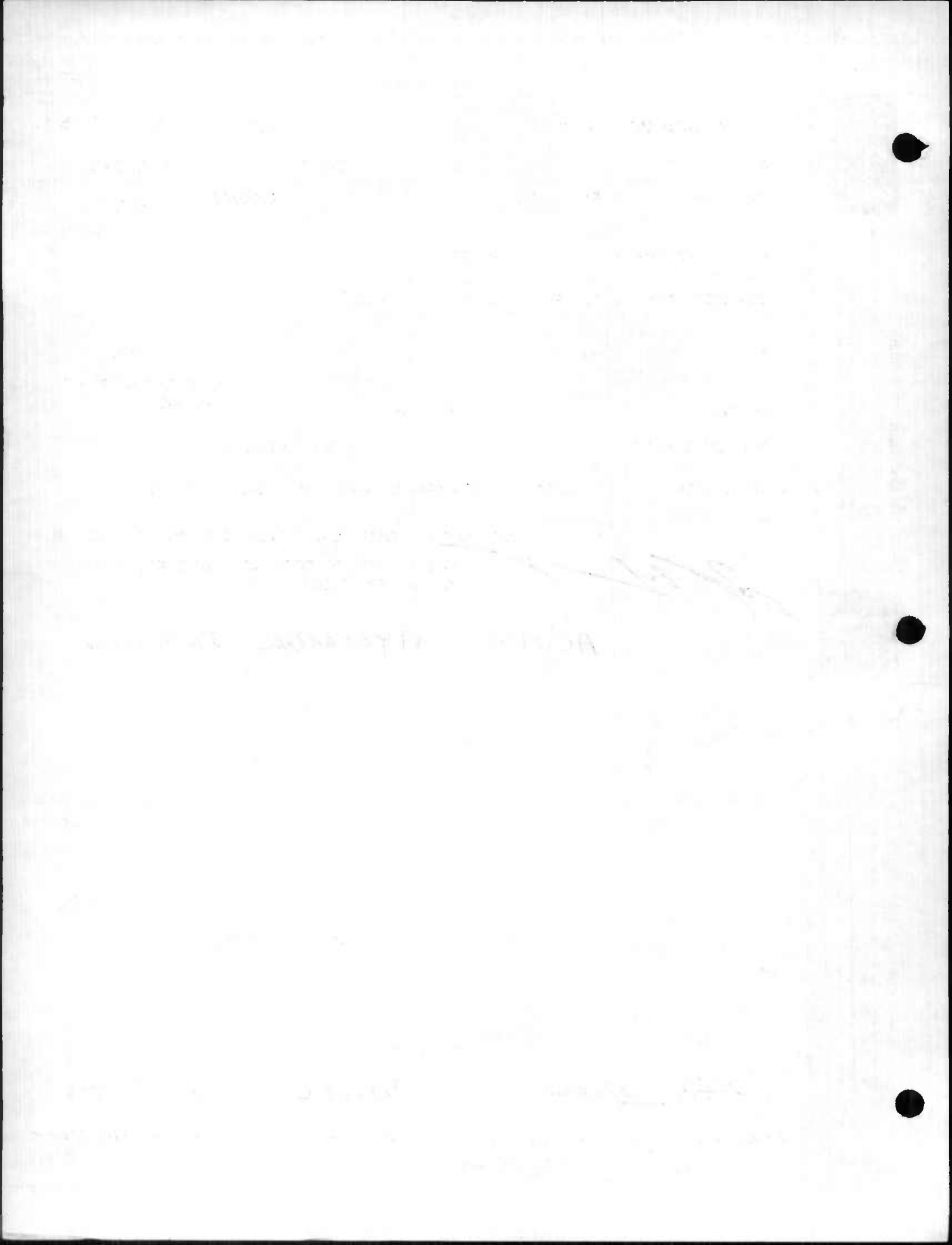
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | | | | |
|---|--|---|--|--|--------------------------------|--|--|
| 1. Decedent's Name (First, Middle, Last) ROSE ANGELINA FURNARI | | | | 2. Date of Death Month Day Year DEC. 17 1997 | | 3. Time of Death 5:15 A.M. | |
| 4a. Facility Name (If not institution, give street and number) STELLA MARIS | | | | 4b. City, Town, or Location of Death TOWSON | | 4c. County of Death BALTIMORE | |
| 5. Social Security Number 217-03-0106 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 91 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) 6/26/06 | |
| 9. Birthplace (State or Foreign Country) Maryland | | | | | | | |
| 10a. State MD | | 10b. County BALTIMORE | | 10c. City, Town or Location TOWSON | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10e. Street and Number 8600 LOCH RAVEN BLVD. APT. B | | | | 10f. Zip Code 21286 | | 10g. Citizen of What Country? USA | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8th GRADE College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) SEAMSTRESS | | 16b. Kind of Business/Industry CLOTHING-HOUSE OF WORSTEX | |
| 17. Father's Name (First, Middle, Last) ANTONIO BREGULIO | | | | 18. Mother's Name (First, Middle, Maiden Surname) ROSE VENIZANIO | | | |
| 19a. Informant's Name/Relationship (Type, Print) MARY D. LOBER DAUGHTER | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 333 FAIRWAY LANE Dagsboro, DE 19939 | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) MOST HOLY REDEEMER CEM. | | Date 12/19/97 | | 20c. Location - City or Town, State BALTIMORE, MD | |
| 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility JOHNSON FUNERAL HOME 8521 LOCH RAVEN BLVD. TOWSON, MD 21286 | | | |
| 23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. e. ACUTE MYOCARDIAL INFARCTION Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | |
| 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 28d. Describe how Injury occurred | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| 29b. Signature and title of certifier | | | | 29c. License number D2568C | | 29d. Date signed (Month, Day, Year) 12-18-97 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EBRAHIM IPAKCHI MD 7600 OSLER DRIVE BALTIMORE MD 21204 | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 22 1997 | | | | 32. Registrar's Signature | | | |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

37 38543

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

LILLIAN C. FREY

2. Date of Death

Month Day Year
December 20, 1997

3. Time of Death

9:50 a.m.

4a. Facility Name (If not institution, give street and number)

Charlestown Nursing Center

4b. City, Town, or Location of Death

Catonsville

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

219-20-7647

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

93 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Dec. 22, 1903

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State
Maryland

10b. County

Baltimore

10c. City, Town or Location

Catonsville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

709 Maiden Choice Lane #6106

10f. Zip Code

21228

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☐ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

6

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Saleswoman

16b. Kind of Business/Industry

Department Store

17. Father's Name (First, Middle, Last)

Jacob Hauk

18. Mother's Name (First, Middle, Maiden Surname)

Margaret Stroheker

19a. Informant's Name/Relationship (Type, Print)

Doris Bemis, daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1237 Birch Avenue Arbutus, Maryland 21227

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Loudon Park Cemetery 12/23 Baltimore, Maryland

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Ambrose Funeral Home, Inc. Arbutus
1328 Sulphur Spring Road Maryland 21227

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CONGESTIVE HEART FAILURE

Approximate Interval Between Onset and Death
MONTHS

Due to (or as a consequence of):

b. END STAGE CARDIO MYOPATHY

YEARS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

AORTIC STENOSIS

DEMENTIA

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D26473

29d. Date signed (Month, Day, Year)

December 21, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

BERNARD F KOWSKY, MD. 711 MAIDEN CHOICE LANE, 21228

31. Date filed (Month, Day, Year)

DEC 22 1997

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Name:

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38544

| | | | | | | | | | | |
|---|---|--------------------------|---|--|--|---|--|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) ANN GRIFFIN | | | | | | 2. Date of Death Month Day Year DECEMBER 17 1997 | | 3. Time of Death 04:21AM | |
| | 4a. Facility Name (If not institution, give street and number) HARBOR HOSPITAL CENTER | | | | | | 4b. City, Town, or Location of Death BALTIMORE | | 4c. County of Death NA | |
| Funeral Director | 5. Social Security Number 216-24-2177 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 74 Yrs. | | 8. Date of Birth (Month, Day, Year) 5/15/23 | | 9. Birthplace (State or Foreign Country) VA | |
| | Usual Residence of Decedent | | | | | | | | | |
| 10a. State MD | | 10b. County NA | | 10c. City, Town or Location BALTIMORE | | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 10e. Street and Number 2603 Spelman Rd. | | | | | | 10f. Zip Code 21225 | | 10g. Citizen of What Country? USA | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: Black | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4or 5+) NA | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Domestic | | | 16b. Kind of Business/Industry Homes | | | |
| 17. Father's Name (First, Middle, Last) Wyatt Smith | | | | | | 18. Mother's Name (First, Middle, Maiden Surname) Connie Smith | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Cecelia Simpson Daughter-in-law | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4624 Frederick Ave Baltimore MD 21229 | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) MT Zion | | | 20c. Location - City or Town, State 12-26-97 Lansdowne MD | | | | |
| 21. Signature of Funeral Service Licensee | | | | | | 22. Name and Address of Facility Albert P. Wylie FHPA 638 Mc Gilman Street 21217 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>a. EXTENSIVE METASTATIC CARCINOMA OF LEFT LUNG Due to (or as a consequence of):</p> <p>b. SEVERE ELECTROLYTE IMBALANCE Due to (or as a consequence of):</p> <p>c. UNCONTROLLED HYPERTENSION Due to (or as a consequence of):</p> <p>d.</p> </div> <div style="width: 35%;"> <p>Approximate Interval Between Onset and Death</p> <p>23 DAYS.</p> <p>20 DAYS.</p> <p>20 DAYS.</p> </div> </div> <p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</p> | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| | | | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | | | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | |
| 29b. Signature and title of certifier | | | 29c. License number AS2441614 A6 | | | 29d. Date signed (Month, Day, Year) DECEMBER 17 1997 | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SUMABALA KASIBHOOTLA 3001 SHANDOVER ST BALTIMORE MD 21225 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 22 1997 | | | 32. Registrar's Signature | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

[Faint, illegible handwriting throughout the page, possibly bleed-through from the reverse side.]

x

x

[Faint, illegible handwriting at the bottom of the page, possibly bleed-through from the reverse side.]

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

87 38545

| | | | | | |
|---|--|--|---|--------------------------------|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) <u>NIRMALA</u> | | 2. Date of Death Month <u>December</u> Day <u>15</u> Year <u>1997</u> | | 3. Time of Death <u>2:25 AM</u> |
| | 4a. Facility Name (If not institution, give street and number) <u>Washington Adventist Hospital</u> | | 4b. City, Town, or Location of Death <u>Takoma Park</u> | | 4c. County of Death <u>Montgomery</u> |
| Funeral Director | 5. Social Security Number <u>212-64-3390</u> | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) <u>74</u> Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. |
| | 8. Date of Birth (Month, Day, Year) <u>June 1, 1923</u> | | 9. Birthplace (State or Foreign Country) <u>India</u> | | |
| To Be Completed by Funeral Director | Usual Residence of Decedent | | | | |
| | 10a. State <u>MD</u> | 10b. County <u>Montgomery</u> | 10c. City, Town or Location <u>Silver Spring</u> | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| | 10e. Street and Number <u>1912 Powder Mill Road</u> | | 10f. Zip Code <u>20903</u> | | 10g. Citizen of What Country? <u>USA</u> |
| | 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
| | 14. Race - American Indian, Black, White, etc. Specify: <u>Indian</u> | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>8</u> College (1-4 or 5+) <u>0</u> | | |
| | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>Homemaker</u> | | 16b. Kind of Business/Industry <u>Own Home</u> | | |
| | 17. Father's Name (First, Middle, Last) <u>Behari Lal Ranjan</u> | | 18. Mother's Name (First, Middle, Maiden Surname) <u>Daulat Bai</u> | | |
| | 19a. Informant's Name/Relationship (Type, Print) <u>Meena Narang/Daughter</u> | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>2007 W. Joppa Road, Lutherville, Maryland 21093</u> | | |
| | 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) <u>Baltimore Washington Cr.</u> | | 20c. Location - City or Town, State <u>Laurel, Maryland</u> |
| | 21. Signature of Funeral Service Licensee <u>James H. Hoke</u> | | 22. Name and Address of Facility <u>Fleck Funeral Home, Inc.</u> <u>7601 Sandy Spring Road, Laurel, Maryland 20707</u> | | |
| Physician /Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | |
| | Immediate Cause (Final disease or condition resulting in death) a. <u>Myocardial infarction</u> | | | | Approximate Interval Between Onset and Death <u>days</u> |
| | Due to (or as a consequence of): | | | | |
| | b. Due to (or as a consequence of): | | | | |
| c. Due to (or as a consequence of): | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d. Due to (or as a consequence of): | | | | | |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | |
| | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | |
| | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | |
| | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | |
| | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | |
| | 28b. Time of Injury <u>M</u> | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | |
| | 29b. Signature and title of certifier <u>David M. Brill MD</u> | | 29c. License number <u>034601</u> | | 29d. Date signed (Month, Day, Year) <u>12/15/97</u> |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <u>DAVID M. BRILL, 7600 CARROLL AVE, TAKOMA PARK, MD 20912</u> | | | | | |
| 31. Date filed (Month, Day, Year) <u>DEC 22 1997</u> | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 38546

Certificate of Death

Reg. No.

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

ISAIAH GRIFFITHS

2. Date of Death

Month DEC Day 14 Year 1997

3. Time of Death

1340

4a. Facility Name (If not institution, give street and number)

Howard County General Hospital

4b. City, Town, or Location of Death

Columbia

4c. County of Death

Howard County

5. Social Security Number

N/A

6. Sex

M M F

7. Age (In yrs. last birthday)

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

5

8. Date of Birth

(Month, Day, Year)

Dec. 9, 1997

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Ft. Meade

10d. Inside City Limits

1 Yes 2 No

10e. Street and Number

7101-C Madden Court

10f. Zip Code

20755

10g. Citizen of What Country?

USA

11. Marital Status

X Never Married 2 Married

3 Widowed 4 Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 Yes 2 No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 No Specify:

14. Race - American Indian,

Black, White, etc.

Specify Black

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

n/a

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

n/a

16b. Kind of Business/Industry

n/a

17. Father's Name (First, Middle, Last)

Peter Bonitto Griffiths

18. Mother's Name (First, Middle, Maiden Surname)

Natalie Regina McPhatter

19a. Informant's Name/Relationship (Type, Print)

Mr. Peter B. Griffiths/father

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7171-C Madden Court, Ft. Meade, MD 20755

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State

4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Columbia Memorial Park

Date

12-18-97 Clarksville, MD

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Slack Funeral Home, PA.

Ellicott City, Maryland 21043

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate
Interval Between
Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. EXTREME PREMATURITY

5 DAYS

Due to (or as a consequence of):

b. SEPSIS

5 DAYS

Due to (or as a consequence of):

c. DISSEMINATED INTRAVASCULAR COAGULATION

2 DAYS

Due to (or as a consequence of):

d. RESPIRATORY DISTRESS SYNDROME

5 DAYS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

PULMONARY HEMORRHAGE

BILATERAL INTRAVENTRICULAR HEMORRHAGES

RENAL FAILURE

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

1 Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

25. Was case referred to medical examiner?

1 Yes 2 No

Hospital:

1 Inpatient 2 ER/Outpatient 3 DOA

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death

1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 Yes 2 No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only one)

29b. Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D39917

29d. Date signed (Month, Day, Year)

DEC 14 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GARY BLECHMAN M.D. 5755 CEDAR LANE, COLUMBIA, MD 21044

31. Date filed (Month, Day, Year)

DEC 22 1997

32. Registrar's Signature

Julia Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be completed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38547

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

ALBERTA GALES

2. Date of Death

DEC 19 1997

3. Time of Death

12:54pm

4a. Facility Name (If not institution, give street and number)

236 S. Mount Olivet Lane

4b. City, Town, or Location of Death

Baltimore City

4c. County of Death

N/A

5. Social Security Number

251-84-6612

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

82 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

07 12 1915

9. Birthplace (State or Foreign Country)

South Carolina

Usual Residence of Decedent

10e. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore City

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

236 S. Mount Olivet Lane

10f. Zip Code

21229

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
unknown

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

N/A

17. Father's Name (First, Middle, Last)

Liston Mashack

18. Mother's Name (First, Middle, Maiden Surname)

Minnie Mashack

19a. Informant's Name/Relationship (Type, Print)

Ernestine Marcus/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

236 S. Mount Olivet Lane, Baltimore, Maryland 21229

20e. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Druid Ridge Cemetery

Date

12/23

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Harry P. Close

22. Name and Address of Facility

William C. Brown Community Funeral Home
1206 W. North Avenue, Baltimore, Maryland 21217

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. SEPSIS

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

3 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. INFECTED DECUBITUS ULCERS

Due to (or as a consequence of):

1 yr

c. DEMENTIA

Due to (or as a consequence of):

10 yr

d. STROKE

10 yrs

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and Title of certifier

Sarkara

29c. License number

J21649

29d. Date signed (Month, Day, Year)

DEC 21 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SARABANDI BASKARAN 3455 Wilkens Ave. Baltimore, MD 21229

31. Date filed (Month, Day, Year)

DEC 22 1997

Registrar's Signature

John Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68750,

To the Hospital or Attending Physician: The law requires that the death certificate be completed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **97 38548**
Certificate of Death

Reg. No.

| | | | | | | | | | | |
|--|---|---------------------------------|---|---|--|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) BETTY RUTH GIDDINGS | | | | | | 2. Date of Death Month Day Year DECEMBER 19 1997 | | 3. Time of Death 5:59 PM | |
| | 4a. Facility Name (If not institution, give street and number) HARBOR HOSPITAL CENTER | | | | | | 4b. City, Town, or Location of Death BALTIMORE | | 4c. County of Death N/A | |
| Funeral Director | 5. Social Security Number 233-50-3782 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 65 Yrs. | | 8. Date of Birth (Month, Day, Year) 10/14/1932 | | 9. Birthplace (State or Foreign Country) West Virginia | |
| | Usual Residence of Decedent | | | | | | | | | |
| 10a. State MD | | 10b. County Baltimore | | 10c. City, Town or Location Arbutus | | | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| 10e. Street and Number 1305 Stevens Avenue | | | | 10f. Zip Code 21227 | | 10g. Citizen of What Country? United States | | | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No, if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 Collega (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Secretary | | | 16b. Kind of Business/Industry State Government | | | |
| 17. Father's Name (First, Middle, Last) Edward Lewis | | | | | | 18. Mother's Name (First, Middle, Maiden Summa) Rayford Ruth Reumers | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Angela Marie Schneider | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1305 Stevens Avenue Arbutus, Maryland 21227 | | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Glen Haven | | 20c. Location - City or Town, State 12/22 Glen Burnie, MD | | | | |
| 21. Signature of Funeral Service Licensee | | | | | | 22. Name and Address of Facility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd. Arbutus, MD 21227 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. ACUTE MYOCARDIAL INFARCTION Due to (or as a consequence of): 1 DAY b. DISSEMINATED INTRAVASCULAR COAGULATION Due to (or as a consequence of): 1 DAY c. UNCONTROLLED SEPSIS Due to (or as a consequence of): 1 DAY d. CONGESTIVE HEART FAILURE, DIABETES MELLITUS { Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | |
| | | | | | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | |
| 29b. Signature and title of certifier M.D. | | | | | | 29c. License number AS2441614 A6 | | 29d. Date signed (Month, Day, Year) DECEMBER 19 1997 | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) SUMABALA KASIRHOTLA 3001 S. HANDOVER ST BALTIMORE MD, 21225 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 22 1997 | | | 32. Registrar's Signature | | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68780.

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

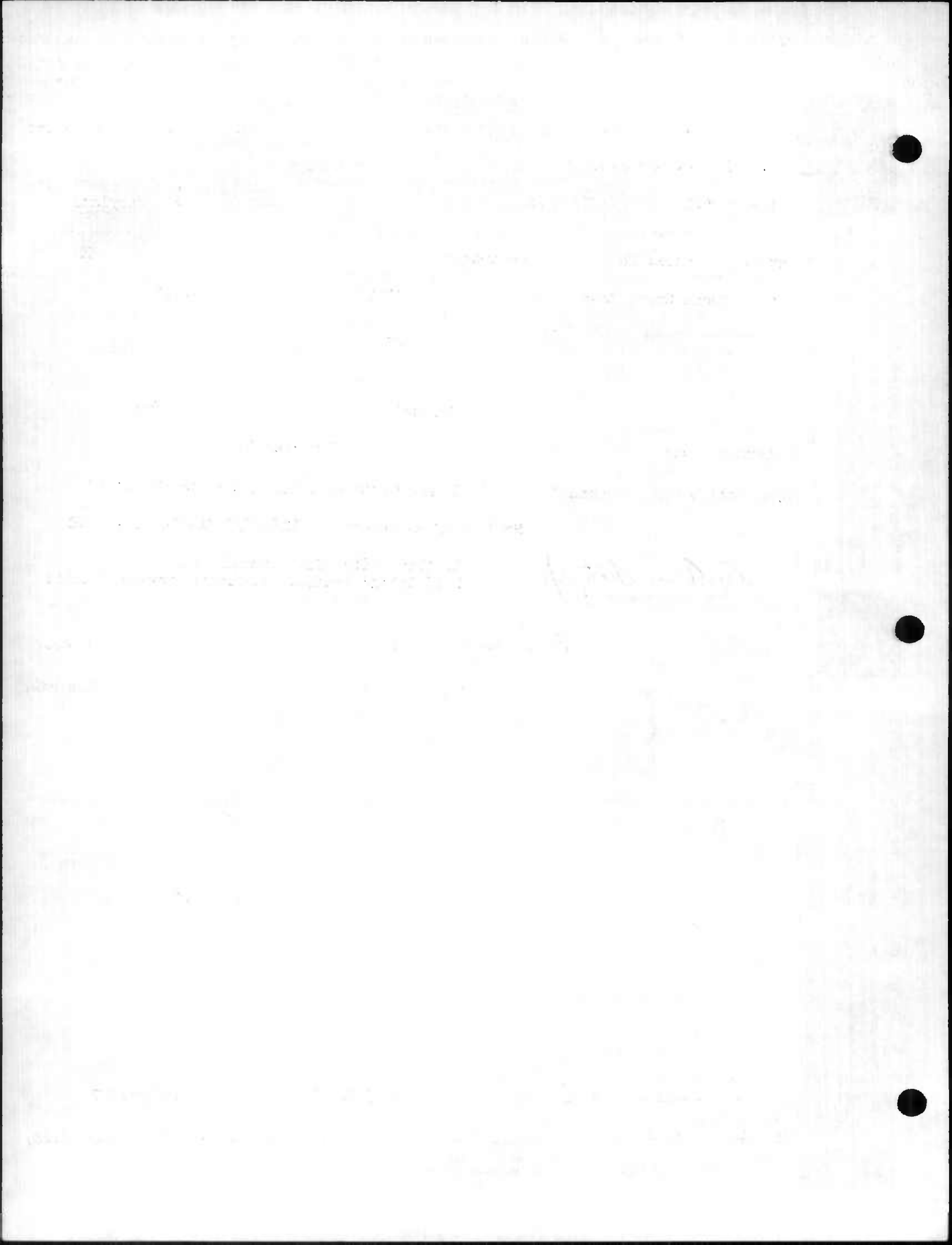
97 38549

| | | | | | | | | | | | |
|---|---|--|--|---|--|--|--|---|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Marlyn J. Hollabaugh | | | | | | 2. Date of Death Month Day Year Dec. 21, 1997 | | 3. Time of Death 1520 hrs | | |
| | 4a. Facility Name (If not institution, give street and number) 96 Pleasant Grove Road | | | | | | 4b. City, Town, or Location of Death Conowingo | | 4c. County of Death | | |
| Funeral Director | 5. Social Security Number 212-32-7471 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 62 Yrs. | | 8. Date of Birth (Month, Day, Year) Sep 8, 1935 | | 9. Birthplace (State or Foreign Country) Maryland | | |
| | 10a. State Maryland | | 10b. County Cecil Co | | 10c. City, Town or Location Conowingo | | 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | |
| 10e. Street and Number 96 Pleasant Grove Road | | 10f. Zip Code 21918 | | 10g. Citizen of What Country? U.S.A | | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Bar Maid | | 16b. Kind of Business/Industry Reese Inn | | 14. Race - American Indian, Black, White, etc. Specify: White | | | | | |
| 17. Father's Name (First, Middle, Last) Norman Sloat | | | | | | 18. Mother's Name (First, Middle, Maiden Surname) Margaret Cox | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Lynn Hollabaugh (Husband) | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 96 Pleasant Grove Road, Conowingo, Md 21918 | | | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Holly Hill Cemetery | | Date 12/27/97 | | 20c. Location - City or Town, State Middle River, Md | | | |
| 21. Signature of Funeral Service Licensee A. Alan Seitz, Jr. | | | | | | 22. Name and Address of Facility A. Alan Seitz, Jr. Funeral Home 3818 Roland Avenue, Baltimore, Maryland 21211 | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Respiratory Failure Due to (or as a consequence of): b. Small cell lung cancer Due to (or as a consequence of): c. Due to (or as a consequence of): d. Approximate interval Between Onset and Death 1 hour 9 months | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Asthma | | | | | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | |
| | | | | | | | | | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| | | | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | | | 28a. Date of injury (Month, Day, Year) | | 28b. Time of injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | | | | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | |
| 29b. Signature and title of certifier L. Austin Doyle MD | | | | | | 29c. License number 023809 | | 29d. Date signed (Month, Day, Year) 12/22/97 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) L. Austin Doyle MD Greenbaum Cancer Ctr., 22 S. Greene St., Balt., MD 21201 | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 22 1997 | | | | | | 32. Registrar's Signature J. Davidson-Randall | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg.

97-38550

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Norma I. Hays

2. Date of Death

December 19 1997 16:06

4a. Facility Name (If not institution, give street and number)

Union Memorial Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

213-26-8787

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

66 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Apr 28, 1931

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3514 Elm Avenue

10f. Zip Code

21211

10g. Citizen of What Country?

U.S.A

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
6

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Home Maker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Bauer

18. Mother's Name (First, Middle, Maiden Surname)

unk

19a. Informant's Name/Relationship (Type, Print)

Alfred W. Hays (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2 Fullerton Heights Avenue, Baltimore, Md 21236

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Garrison Forest VA Cem

Date

12/23/97

20c. Location - City or Town, State

Owings Mills, Maryland

21. Signature of Funeral Service Licensee

A. Alan Seitz, Jr.

22. Name and Address of Facility

A. Alan Seitz, Jr. Funeral Home

3818 Roland Avenue, Baltimore, Maryland 21211

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Exsanguination 2° to Ruptured Shrs.

Due to (or as a consequence of):

b. AAA

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

10YRS

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Severe CAD, Atrial
Fibrillation

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?
1 ☒ Yes 2 ☐ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

William Roe Jr., MD

29c. License number

D29579

29d. Date signed (Month, Day, Year)

December 19, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

William Roe Jr., MD

Union Memorial Hosp.

Balt. MD 21218

31. Date filed (Month, Day, Year)

DEC 22 1997

32. Registrar's Signature

John Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

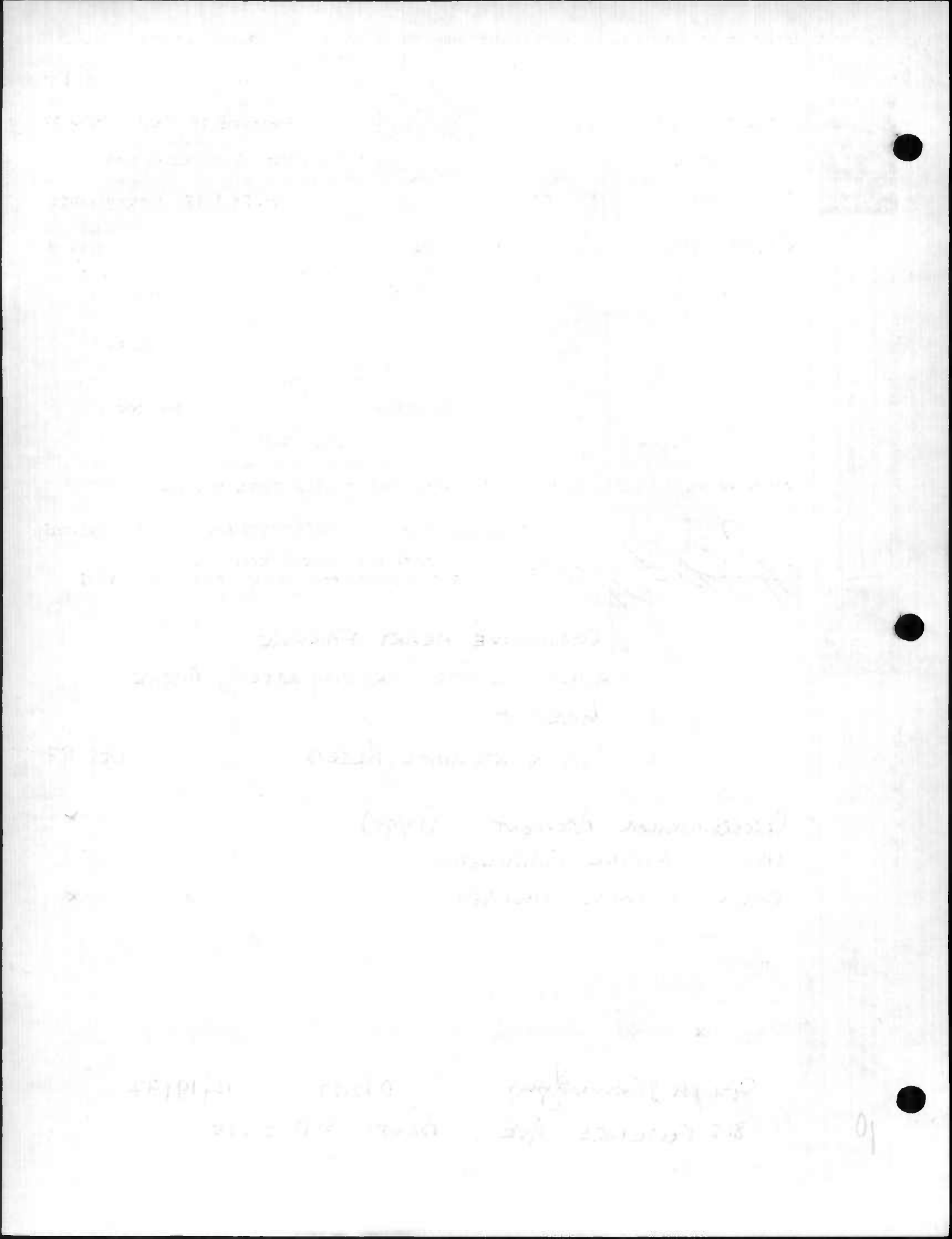
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38551

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|---|--|---|---|--|---|--|---|---|----|---------------------------------|--|--|--|--|--|----------------------------------|--|--|--|--|--|--|----|--|--|--|--|--|--|----------------------------------|--|--|--|--|--|--|---|----|---------------|--|--|--|--|--|----------------------------------|--|--|--|--|--|--|----|-------------------------------|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Helene Winifred Houp | | | | 2. Date of Death Month December Day 19 Year 1997 | | 3. Time of Death 2:00 AM | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 4a. Facility Name (If not institution, give street and number) 6 Tinker Road | | | | 4b. City, Town, or Location of Death Middle River | | 4c. County of Death Baltimore | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Funeral Director | 5. Social Security Number 202-30-0401 | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 85 Yrs. | If Under 1 Year Months | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) Nov. 24, 1912 | | 9. Birthplace (State or Foreign Country) Pennsylvania | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | Usual Residence of Decedent | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State Maryland | 10b. County Baltimore | | 10c. City, Town or Location Middle River | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 10e. Street and Number 6 Tinker Road | | | 10f. Zip Code 21220 | | 10g. Citizen of What Country? U.S.A. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+) | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Housewife | | 16b. Kind of Business/Industry Own Home | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 17. Father's Name (First, Middle, Last) Unknown | | | | 18. Mother's Name (First, Middle, Maiden Surname) Grace Saylor | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Patricia Ann Blevins (Daughter) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4 Tinker Road Middle River, Maryland 21220 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Alto Rest Park | | Date 12/22/1997 | | 20c. Location - City or Town, State Blair Co., Pennsylvania | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility Bruzdinski Funeral Home P.A. 1407 Old Eastern Avenue Essex, Md. 21221 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one disease on each line. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | <table border="0"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a.</td> <td colspan="6">CONGESTIVE HEART FAILURE</td> </tr> <tr> <td colspan="7">Due to (or as a consequence of):</td> </tr> <tr> <td>b.</td> <td colspan="6">ATHEROSCLEROTIC CORONARY ARTERY DISEASE</td> </tr> <tr> <td colspan="7">Due to (or as a consequence of):</td> </tr> <tr> <td rowspan="3">Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last</td> <td>c.</td> <td colspan="6">ANEMIA</td> </tr> <tr> <td colspan="7">Due to (or as a consequence of):</td> </tr> <tr> <td>d.</td> <td colspan="6">GASTROINTESTINAL BLEED</td> </tr> </table> | | | | | | | | Immediate Cause (Final disease or condition resulting in death) | a. | CONGESTIVE HEART FAILURE | | | | | | Due to (or as a consequence of): | | | | | | | b. | ATHEROSCLEROTIC CORONARY ARTERY DISEASE | | | | | | Due to (or as a consequence of): | | | | | | | Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | c. | ANEMIA | | | | | | Due to (or as a consequence of): | | | | | | | d. | GASTROINTESTINAL BLEED | | | | |
| Immediate Cause (Final disease or condition resulting in death) | a. | CONGESTIVE HEART FAILURE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | Due to (or as a consequence of): | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | b. | ATHEROSCLEROTIC CORONARY ARTERY DISEASE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | Due to (or as a consequence of): | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | c. | ANEMIA | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | Due to (or as a consequence of): | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | d. | GASTROINTESTINAL BLEED | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CEREBROVASCULAR ACCIDENT (10/95) CHRONIC ATRIAL FIBRILLATION CHRONIC COCAINE THERAPY. | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | 28d. Describe how injury occurred | | | | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 29b. Signature and title of certifier | | | | 29c. License number D30133 | | 29d. Date signed (Month, Day, Year) 12/19/97 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 805 FUSELARE AVE. BALTO MD 21220 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| State Registrar | 31. Date filed (Month, Day, Year) DEC 22 1997 | | | | 32. Registrar's Signature | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 38552
Certificate of Death

Reg. No.

Physician
/Medical
Examiner

| | | | | | | | | | |
|--|--|---------------------------------|--|--|---------------------------|--------------------------|--|------------------------------------|---|
| 1. Decedent's Name (First, Middle, Last) <i>William Hawkins</i> | | | | 2. Date of Death Month <i>December</i> Day <i>18</i> Year <i>1997</i> | | | | 3. Time of Death <i>8:01 AM</i> | |
| 4a. Facility Name (If not institution, give street and number) <i>Maryland General Hospital</i> | | | | 4b. City, Town, or Location of Death <i>Baltimore City</i> | | | | 4c. County of Death <i>NA</i> | |
| 5. Social Security Number <i>213-22-2411</i> | | 6. Sex <i>1</i> M <i>2</i> F | 7. Age (In yrs. last birthday) <i>75</i> Yrs. | If Under 1 Year Months | If Under 24 Hrs. Hours | If Under 24 Hrs. Min. | 8. Date of Birth (Month, Day, Year) <i>12/21/21</i> | | 9. Birthplace (State or Foreign Country) <i>DC</i> |

Funeral
Director

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 10a. State <i>MD</i> | | 10b. County <i>NA</i> | | 10c. City, Town or Location <i>BALTIMORE</i> | | 10d. Inside City Limits <i>1</i> Yes <i>2</i> No | |
| 10e. Street and Number <i>501 W. FRANKLIN ST.</i> | | | | 10f. Zip Code <i>21201</i> | | 10g. Citizen of What Country? <i>USA</i> | |
| 11. Marital Status <i>1</i> Never Married <i>2</i> Married <i>3</i> Widowed <i>4</i> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <i>1</i> Yes <i>2</i> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <i>1</i> Yes <i>2</i> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: <i>Black</i> | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>Unknown</i> College (1-4 or 5+) <i>Unknown</i> | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>laborer</i> | | 16b. Kind of Business/Industry <i>Construction</i> | |
| 17. Father's Name (First, Middle, Last) <i>Unknown</i> | | | | 18. Mother's Name (First, Middle, Maiden Surname) <i>Unknown</i> | | | |
| 19a. Informant's Name/Relationship (Type, Print) <i>Paul Black Counselor</i> | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>501 W. FRANKLIN ST. BALTO. MD 21201</i> | | | |
| 20a. Method of Disposition <i>1</i> Burial <i>2</i> Cremation <i>3</i> Removal from State <i>4</i> Donation <i>5</i> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) <i>MT. ZION CEMETERY</i> | | 20c. Location - City or Town, State <i>Landowne, MD</i> | | 20d. Date <i>12/19/97</i> | |
| 21. Signature of Funeral Service Licensee <i>[Signature]</i> | | | | 22. Name and Address of Facility <i>ALBERT P. WYLLIE 638 N. GILMORE ST. BALTO. MD 21217</i> | | | |

To Be Completed by Funeral Director

Physician
/Medical
Examiner

| | | | |
|--|--|--|--|
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. <i>Arrhythmia / Seizure</i> Due to (or as a consequence of): f. <i>Dementia</i> Due to (or as a consequence of): g. <i>Status Post Craniotomy due to hematoma</i> Due to (or as a consequence of): h. <i>Hypertension</i> | | Approximate Interval Between Onset and Death | |
|--|--|--|--|

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Schizophrenia</i> <i>Status Post percutaneous angioplasty</i> <i>Alumina</i> | | | | 23b. Did tobacco use contribute to the cause of death? <i>1</i> Yes <i>2</i> No <i>3</i> Probably <i>4</i> Unknown | | | |
| 24a. Was an autopsy performed? <i>1</i> Yes <i>2</i> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? <i>1</i> Yes <i>2</i> No | | | |
| 25. Was case referred to medical examiner? <i>1</i> Yes <i>2</i> No | | 26. Place of Death (Check only one) Hospital: <i>1</i> Inpatient <i>2</i> ER/Outpatient <i>3</i> DOA Other: <i>4</i> Nursing Home <i>5</i> Residence <i>6</i> Other (Specify) | | | | | |
| 27. Manner of Death <i>1</i> Natural <i>2</i> Accident <i>3</i> Suicide <i>4</i> Homicide <i>5</i> Pending Investigation <i>6</i> Could not be determined | | 28a. Date of injury (Month, Day, Year) | | 28b. Time of Injury <i>M</i> | | 28c. Injury at Work? <i>1</i> Yes <i>2</i> No | |
| 28d. Describe how injury occurred | | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) <i>1</i> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <i>2</i> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| 29b. Signature and title of certifier <i>[Signature] MD</i> | | 29c. License number <i>D 31464</i> | | 29d. Date signed (Month, Day, Year) <i>12/19/97</i> | | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <i>SHUTTS A. HARRIS 821 N Eutam St Suite 308 Balt. MD 21201</i> | | | | | | | |
| 31. Date filed (Month, Day, Year) <i>DEC 22 1997</i> | | 32. Registrar's Signature <i>[Signature]</i> | | | | | |

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be completed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit.

WILLIAM HAWKINS

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38553

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Lillian Bingel Hooper

2. Date of Death

Month
DecDay
17Year
1997

3. Time of Death

11:35 PM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Laurel Regional Hospital

4b. City, Town, or Location of Death

Laurel

4c. County of Death

Prince George

5. Social Security Number

125-22-5033

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

71 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Jan 11, 1926

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Laurel

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

316 Park Hall South

10f. Zip Code

20724

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Navar Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Herman V. Bingel

18. Mother's Name (First, Middle, Maiden Surname)

Eva H. Hutchings

19a. Informant's Name/Relationship (Type, Print)

Evan E. Hooper/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

316 Park Hall South Laurel, MD 20724

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Baltimore Washington Crem. 12/20

Date

20c. Location - City or Town, State

Laurel, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Fleck Funeral Home, Inc.

7601 Sandy Spring Rd Laurel, MD 20707

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a. Acute Myocardial Infarction

3 Hours

Due to (or as a consequence of):

b. Coronary Artery Disease

10 Years

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes Mellitis

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending

investigation

6 ☐ Could not be

determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)X ☒

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D 24721

29d. Date signed (Month, Day, Year)

December 18, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Syed Sadiq 14800 4th Street Laurel, Maryland 20707

31. Date filed (Month, Day, Year)

DEC 22 1997

32. Signature

J. Anderson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 24a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38554

| | | | | | | | | |
|---|--|--|---|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) JANE FRANCES HIPSELEY | | | | 2. Date of Death Month Day Year December 15, 1997 | | 3. Time of Death 4:45 p | |
| | 4a. Facility Name (If not institution, give street and number) Oakcrest Village; 8800 Walther Blvd., #1010 | | | | 4b. City, Town, or Location of Death Baltimore | | 4c. County of Death Baltimore County | |
| Funeral Director | 5. Social Security Number 214-22-2105 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 71 Yrs. | | 8. Date of Birth (Month, Day, Year) August 9, 1926 | |
| | 9. Birthplace (State or Foreign Country) Maryland | | 10a. State Maryland | | 10b. County Baltimore County | | 10c. City, Town or Location Baltimore | |
| To Be Completed by Funeral Director | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 10e. Street and Number 8800 Walther Blvd., #1010 | | 10f. Zip Code 21234 | | 10g. Citizen of What Country? USA | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: white | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) registered nurse | | 16b. Kind of Business/Industry hospital/health care | | | |
| | 17. Father's Name (First, Middle, Last) William Russell Gardiner | | | | 18. Mother's Name (First, Middle, Maiden Summa) Margaret Cecil | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Mr. D. Patrick Hipsley/son | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 245 Gralan Road, Catonsville, Maryland 21228 | | | |
| | 20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Data | | 20c. Location - City or Town, State | | | |
| | 21. Signature of Funeral Service Licensee <i>[Signature]</i> | | 22. Name and Address of Facility State Anatomy Board Baltimore, Maryland 21201 | | | | | |
| | 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>Respiratory Failure</i> Due to (or as a consequence of): b. <i>Out cell lung cancer</i> Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | | | | | Approximate Interval Between Onset and Death <i>less</i> <i>yes</i> | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | |
| | | | | | | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28d. Describe how injury occurred | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| | 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier <i>Jany Watinsky M.D.</i> | | 29c. License number D 09559 | | 29d. Date signed (Month, Day, Year) 12/17/97 | |
| State Registrar | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) L. WATERBURY, M.D. JHMC 4440 Eastern Ave, Balt. Md 21224 | | | | | | | |
| | 31. Date filed (Month, Day, Year) DEC 22 1997 | | 32. Registrar's Signature <i>[Signature]</i> | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be signed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 38555

Certificate of Death

Reg. No.

| | | | | | | | | | | | |
|--|---|---|--|---|--|---------------------------------|---|--|---|-----------------------------------|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) <i>George Louis Hafner</i> | | | | 2. Date of Death Month Day Year <i>December 14, 1997</i> | | | | 3. Time of Death <i>8:36 pm</i> | | |
| | 4a. Facility Name (If not institution, give street and number) <i>Adventist Hospital</i> | | | | 4b. City, Town, or Location of Death <i>Takoma Park</i> | | | | 4c. County of Death <i>Montgomery County</i> | | |
| Funeral Director | 5. Social Security Number <i>128-03-0718</i> | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) <i>92</i> Yrs. | | 8. Date of Birth (Month, Day, Year) <i>October 26, 1905</i> | | 9. Birthplace (State or Foreign Country) <i>New York</i> | | |
| | Usual Residence of Decedent | | | | | | | | | | |
| 10a. State <i>Maryland</i> | | 10b. County <i>Howard County</i> | | 10c. City, Town or Location <i>Columbia</i> | | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| 10e. Street and Number <i>5400 Vantage Point Road</i> | | | | 10f. Zip Code <i>21044</i> | | | | 10g. Citizen of What Country? <i>USA</i> | | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: <i>white</i> | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>service manager</i> | | | | 16b. Kind of Business/Industry <i>automobile repair</i> | | | |
| 17. Father's Name (First, Middle, Last) <i>Peter Hafner</i> | | | | 18. Mother's Name (First, Middle, Maiden Surname) <i>Louisa (unknown)</i> | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) <i>Ms. Georgia L. Eacker/daughter</i> | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>3619 Folly Quarter Road, Ellicott City, MD 21042</i> | | | | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Maple Grove Cemetery</i> | | | | 20c. Location - City or Town, State <i>12-22-97 Kew Gardens, NY</i> | | | |
| 21. Signature of Funeral Service Licensee <i>[Signature]</i> M00535 | | | | 22. Name and Address of Facility <i>Slack Funeral Home, P.A. Ellicott City, Maryland 21043</i> | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>a. <i>HYPOXEMIA</i> Due to (or as a consequence of):</p> <p>b. <i>PULMONARY EDEMA AND</i> Due to (or as a consequence of):</p> <p>c. <i>PNEUMONIA</i> Due to (or as a consequence of):</p> <p>d. <i>AORTIC VALVE & CORONARY ARTERY DISEASE</i></p> </div> <div style="width: 15%;"> <p>Approximate Interval Between Onset and Death</p> <p><i>DAYS</i></p> <p><i>2 WEEKS</i></p> <p><i>2 WEEKS</i></p> <p><i>YEARS</i></p> </div> </div> | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>RENAL FAILURE</i> <i>LEUCOCYTOSIS</i> | | | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | | | | | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide | | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury <i>M</i> | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | | |
| 29b. Signature and title of certifier <i>[Signature] MD</i> | | | | 29c. License number <i>D 18551</i> | | | | 29d. Date signed (Month, Day, Year) <i>12/15/97</i> | | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <i>SAMIR NEIMAT, M.D. 7610 CARROLL AV. TAKOMA PARK, MD, 20912</i> | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) <i>DEC 22 1997</i> | | | | 32. Registrar's Signature <i>[Signature]</i> | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38556

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

LUCY FRANCES HOBLITZELL

2. Date of Death

Month Day Year
December 10, 1997

3. Time of Death

4:20 AM

4a. Facility Name (If not institution, give street and number)

Suburban Hospital

4b. City, Town, or Location of Death

Bethesda

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

227-22-6120

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

83

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Aug. 3, 1914

9. Birthplace (State or Foreign Country)

West Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Potomac

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

8811 Victory Lane

10f. Zip Code

20854

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced12. Was Decedent Ever in U.S.
Armed Forces?1 ☒ Yes 2 ☐ No
If Yes, Give
Year or Dates: WWII13. Was Decedent of Hispanic Origin? (Specify Yes or No-
if Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

School Teacher

16b. Kind of Business/Industry

Public School System

17. Father's Name (First, Middle, Last)

John Dempsey Hoblitzell

18. Mother's Name (First, Middle, Maiden Surname)

Juliette M. Smith

19a. Informant's Name/Relationship (Type, Print)

Julie Matheny, Niece

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1009 51st Street, Vienna, West Virginia 26105

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Metropolitan Crematory

12/11/1997

20c. Location - City or Town, State

Alexandria, Virginia

21. Signature of Funeral Service Licensee

Alden Shuck

M00544

22. Name and Address of Facility

STEIN HEBREW MEMORIAL FUNERAL HOME, INC.

232 CARROLL STREET, N.W., WASHINGTON, D.C. 20012

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final
disease or condition
resulting in death)

e. VENTRICULAR TACHYCARDIA

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

1 hour

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. CONGESTIVE HEART FAILURE

Due to (or as a consequence of):

3 months

c. ISCHEMIC CARDIOPATHY

Due to (or as a consequence of):

9 months

d. MYOCARDIAL INFARCTION

9 months

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Mark Milner MD

29c. License number

041520

29d. Date signed (Month, Day, Year)

December 10, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mark Milner MD 6410 Rockledge Drive Bethesda, Maryland 20852

31. Date filed (Month, Day, Year)

DEC 22 1997

32. Registrar's Signature

John Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transitLucy Hoblitzell
Dec 10 1997 4:20 PM
Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38557

| | | | | | | | | | | | |
|---|---|---------------------------------|---|---|--|--|--|--|---|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) MARGARET EVA JOSITIS | | | | | | 2. Date of Death Month Day Year DECEMBER 17 1997 | | 3. Time of Death 11:00 PM | | |
| | 4a. Facility Name (If not institution, give street and number) 2902 CHURCH ROAD | | | | | | 4b. City, Town, or Location of Death PARKVILLE | | 4c. County of Death BALTIMORE | | |
| Funeral Director | 5. Social Security Number 220-01-6802 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 94 Yrs. | | 8. Date of Birth (Month, Day, Year) JANUARY 26 1903 | | 9. Birthplace (State or Foreign Country) MARYLAND | | |
| | Usual Residence of Decedent | | | | | | | | | | |
| 10a. State MARYLAND | | 10b. County BALTIMORE | | 10c. City, Town or Location PARKVILLE | | | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| 10e. Street and Number 2902 CHURCH ROAD | | | | 10f. Zip Code 21234 | | 10g. Citizen of What Country? UNITED STATES | | | | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER | | | 16b. Kind of Business/Industry OWN HOME | | | | |
| 17. Father's Name (First, Middle, Last) MARTIN MATTHEW NAUYALIS | | | | | | 18. Mother's Name (First, Middle, Maiden Surname) ANNA ROLLINS | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) WILLIAM M. JOSITIS (SON) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 115 FELTON ROAD LUTHERVILLE, MARYLAND 21093 | | | | | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) HOLY REDEEMER CEMETERY | | | Date 12-22-97 | | 20c. Location - City or Town, State BALTIMORE, MARYLAND | | | |
| 21. Signature of Funeral Service Licensee  | | | | 22. Name and Address of Facility MITCHELL-WIEDEFELD HOME 6500 YORK ROAD BALTIMORE, MARYLAND 21212 | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last e. Possible Acute MI Due to (or as a consequence of): f. Serious + Systemic Hypertension Due to (or as a consequence of): g. Due to (or as a consequence of): h. | | | | | | | | | | Approximate Interval Between Onset and Death 1-2 L 2-3 Yr | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | |
| | | | | | | | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how Injury occurred | | |
| | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | |
| 29b. Signature and title of certifier  | | | | | 29c. License number D14221 | | | 29d. Date signed (Month, Day, Year) 12-18-97 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TARIQUE FIROZZI, M.D. 223 EASTERN BLVD. BALTIMORE, MARYLAND 21221 | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 22 1997 | | | 32. Registrar's Signature  | | | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "Natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit.

Division of Vital Records, P.O. Box 68760

10-4-74 10:00 AM

10-4-74 10:00 AM

10-4-74 10:00 AM

10-4-74 10:00 AM

10-4-74 10:00 AM

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38558

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

James L. Jenkins

2. Date of Death

Month Day Year
December 18 1997

3. Time of Death

05:15 am

4a. Facility Name (If not institution, give street and number)

Union Memorial Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

5. Social Security Number

224-52-8735

6. Sex

X M 2 F

7. Age (In yrs. last birthday)

59 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Jan 24, 1938

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State
Maryland10b. County
N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

X Yes 2 No

10e. Street and Number

1431 Union Avenue

10f. Zip Code

21211

10g. Citizen of What Country?

USA

11. Marital Status

1 Never Married 2 X Married
3 Widowed 4 Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 X Yes 2 No
If Yes, Give
Year or Dates: 59-6313. Was Decedent of Hispanic Origin? (Specify Yes or No
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 X No Specify:

14. Race - American Indian,
Black, White, etc.

Specify: white

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16e. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Maintenance Supervisor

16b. Kind of Business/Industry

Maintenance

17. Father's Name (First, Middle, Last)

Charles Jenkins

18. Mother's Name (First, Middle, Maiden Surname)

Helen Fleming

19a. Informant's Name/Relationship (Type, Print)

Ellen Jenkins Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1431 Union Avenue Baltimore, Maryland 21211

20e. Method of Disposition

X Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Maryland VA Cemetery

Date

12/22/97

20c. Location - City or Town, State

MD Garrison Forest,

21. Signature of Funeral Service Licensee

Grace H. Carpenter

22. Name and Address of Facility

Burgee-Hennessy Funeral Home
3631 Falls Road Baltimore, MD 2121123a. Part I. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)e. Lung cancer - small cell cancer
Due to (or as a consequence of):Approximate
Interval Between
Onset and Death

b months

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension, coronary artery disease

atrial fibrillation

23b. Did tobacco use contribute to the cause of death?

1 X Yes 2 No 3 Probably 4 Unknown

24e. Was an autopsy
performed?

1 X Yes 2 No

24b. Were autopsy findings
available prior to
completion of cause
of death?

1 X Yes 2 No

25. Was case referred to medical
examiner?

1 Yes 2 X No

Hospital:

1 X Inpatient 2 ER/Outpatient 3 DOA

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death

1 X Natural 5 Pending investigation
2 Accident 6 Could not be determined
3 Suicide 4 Homicide28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury

M

28c. Injury et
Work?

1 Yes 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dannielle Harwood, MD

29c. License number

AT2438946

29d. Date signed (Month, Day, Year)

December 18, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Dannielle Harwood Union Memorial Hospital Baltimore, MD

31. Date filed (Month, Day, Year)

DEC 22 1997

32. Registrar's Signature

John Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "Natural", or items 23a or 28e-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38559

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Kim E. JACKSON

2. Date of Death

Month 12 Day 18 Year 97

3. Time of Death

8:00 P.M.

4a. Facility Name (If not institution, give street and number)

BON SECUR HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

213-62-9257

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

37 Yrs.

Under 1 Year

Months Days

Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year) JULY 30, 1960

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State
MARYLAND

10b. County

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

213 MONROE STREET

10f. Zip Code

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12 TH GRADECollege (1-4 or 5+)
N/A

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

CONSTRUCTION LABORER

16b. Kind of Business/Industry

CONCRETE MASONRY

17. Father's Name (First, Middle, Last)

FLOYD E. JACKSON SR.

18. Mother's Name (First, Middle, Maiden Surname)

HILDA JACKSON

19a. Informant's Name/Relationship (Type, Print)

ELLEN JACKSON / SISTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

103 N. AMITY ST., BALTIMORE, MD.

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

METRO CREMATORY

Date

12/26/97 CATONSVILLE, Md.

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

UNITY FUNERAL HOME 103 W. NORTH AV., Md. 21201

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. PNEUMOCOCCAL PNEUMONIA WITH SEPTICEMIA

DAYS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ACQUIRED IMMUNE DEFICIENCY SYNDROME

ACUTE RENAL FAILURE

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending Investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature] Surgeon General MD

29c. License number

D 26395

29d. Date signed (Month, Day, Year)

12/19/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SURJIT S JULKA MD, 821 N. EUTAW ST. BALTIMORE MD 21201

31. Date filed (Month, Day, Year)

DEC 22 1997

32. Registrar's Signature

[Signature] John Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be completed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.


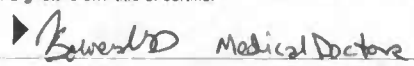

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38560

| | | | | | |
|--|--|---|---|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Samuel E. Johnson | | 2. Date of Death Month DECEMBER Day 17 Year 1997 | | 3. Time of Death 2320 |
| | 4a. Facility Name (If not institution, give street and number) SINAI HOSPITAL | | 4b. City, Town, or Location of Death BALTIMORE | | 4c. County of Death N/A |
| Funeral Director | 5. Social Security Number 220-05-2156 | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 78 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. |
| | 8. Date of Birth (Month, Day, Year) Jan. 5, 1919 | | 9. Birthplace (State or Foreign Country) MD | | |
| To Be Completed by Funeral Director | Usual Residence of Decedent | | 10c. City, Town or Location | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| | 10e. State MD | 10b. County n/a | Baltimore | | |
| | 10e. Street and Number 4214 Ridgewood Ave. | | 10f. Zip Code 21215 | | 10g. Citizen of What Country? USA |
| | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
| 14. Race - American Indian, Black, White, etc. Specify: Black | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6th College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Machinist | |
| 16b. Kind of Business/Industry Continental Can | | 17. Father's Name (First, Middle, Last) unk. | | 18. Mother's Name (First, Middle, Maiden Surname) Lizzie | |
| 19e. Informant's Name/Relationship (Type, Print) Delcia Johnson Whitaker/daughter | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4214 Ridgewood Ave. BALTO., MD 21215 | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Woodlawn Memorial | | 20c. Location - City or Town, State 12/27 Woodlawn, MD | |
| 21. Signature of Funeral Service Licensee  | | 22. Name and Address of Facility James A. Morton & Sons Funeral Home 1701 Laurens St. Balto., MD 21217 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. DISSEMINATED INTRAVASCULAR COAGULOPATHY Due to (or as a consequence of): b. UPPER GASTROINTESTINAL BLEED Due to (or as a consequence of): c. METASTATIC LYMPHOMA Due to (or as a consequence of): d. LACTIC ACIDOSIS | | Approximate Interval Between Onset and Death | | | |
| 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | |
| 24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | |
| 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier  Medical Doctor | | 29c. License number AS-2402321-38-9338 | |
| 29d. Date signed (Month, Day, Year) DECEMBER 17, 1997 | | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) JANELLE R. BOWERS, MD SINAI HOSPITAL 2321 WEST BELVEDERE AVENUE BALTIMORE, MD 21215 | | | |
| 31. Date filed (Month, Day, Year) DEC 22 1997 | | 32. Registrar's Signature  | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

AM

DAVID

JOHNSON Items: 23 part I, 27, 28a-f per ME0 G-755 1/2/98

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38561

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

David Lee Johnson

2. Date of Death

Month Day Year
DECEMBER 19, 1997

3. Time of Death

7:25 P

Funeral
Director

4a. Facility Name (If not institution, give street and number)

BON SECOUR HOSPITAL ER

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

n/a

5. Social Security Number

215-64-7546

6. Sex

M 2 ☐ F

7. Age (In yrs. last birthday)

42 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

December 22, 1954

9. Birthplace (State or Foreign Country)

AL

Usual Residence of Decedent

10a. State

MD

10b. County

n/a

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

702 N. Appelton St.

10f. Zip Code

21217

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: Black

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

12th

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Cook

16b. Kind of Business/Industry

Restaurant

17. Father's Name (First, Middle, Last)

James Johnson

18. Mother's Name (First, Middle, Maiden Surname)

Mary E. Price

19e. Informant's Name/Relationship (Type, Print)

Mary Johnson/mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3701 Twin Lake Ct. apt. 215 Balto, MD 21207

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

King Memorial Park

Date

12/24

20c. Location - City or Town, State

Randallstown, MD

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

James A. Morton & Sons Funeral Home

1701 Laurens St. Balto., MD 21217

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. NARCOTIC INTOXICATION

Due to (or as a consequence of):

Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24e. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending Investigation
2 ☐ Accident 3 ☐ Suicide
4 ☐ Homicide ☒ Could not be determined

28a. Date of Injury

(Month, Day, Year)

found 12/19/97

28b. Time of Injury

found at 6:58

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

found on the sidewalk

28d. Describe how injury occurred

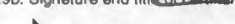
UNKNOWN

28f. Location (Street and Number or Rural Route Number, City or Town, State) Baltimore, Maryland Bentalou & Lexington Sts.

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

OCME

29d. Date signed (Month, Day, Year)

DECEMBER 20, 1997

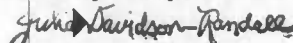
30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

David R Fowler 111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

DEC 22 1997

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38562

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit

State Registrar

6

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | | |
|--|--|---|--|--|--|
| 1. Decedent's Name (First, Middle, Last) Philip Wayne Johnston | | 2. Date of Death Month December Day 21 , Year 1997 | | 3. Time of Death 9:15 p.m. | |
| 4a. Facility Name (If not institution, give street and number) Golden Oaks Nursing Home | | | 4b. City, Town, or Location of Death Laurel | | 4c. County of Death Prince George |
| 5. Social Security Number 217-50-0011 | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 49 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) Jan. 9, 1948 |
| 9. Birthplace (State or Foreign Country) Maryland | | | | | |
| Usual Residence of Decedent | | | | | |
| 10a. State Maryland | 10b. County Prince George | 10c. City, Town or Location Laurel | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10e. Street and Number 7103 Carriage Hill Drive | | 10f. Zip Code 20707 | | 10g. Citizen of What Country? USA | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | |
| 14. Race - American Indian, Black, White, etc. Specify: White | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 0 | | | |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Motor Coach Operator | | 16b. Kind of Business/Industry Public Transportation | | | |
| 17. Father's Name (First, Middle, Last) Charles L. Johnston | | | 18. Mother's Name (First, Middle, Maiden Surname) Gladys Daly | | |
| 19a. Informant's Name/Relationship (Type, Print) Dorothy M. Johnston | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7103 Carriage Hill Drive, Laurel, Maryland 20707 | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Maryland Veterans Ceme. | | 20c. Location - City or Town, State 12/23 Crownsville, Maryland | |
| 21. Signature of Funeral Service Licensee  | | | 22. Name and Address of Facility Fleck Funeral Home, Inc. 7601 Sandy Spring Road, Laurel, Maryland 20707 | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Metastatic Lung Cancer Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | | | | Approximate Interval Between Onset and Death Days |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | 23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury M | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | 28d. Describe how injury occurred |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier  | | 29c. License number D43260 | 29d. Date signed (Month, Day, Year) December 23, 1997 |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jenny Y Moy, MD 14333 Laurel Bowie Rd #307 Laurel MD 20853 | | | | | |
| 31. Date filed (Month, Day, Year) DEC 22 1997 | | 32. Registrar's Signature  | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Item#18perFHG754 12/24/97 EW
Item: 26 Per Phy Film G-754 12-22-97RC

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38563

| | | | | | | | | |
|---|---|--|---|--|---|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) LILLIE LUNSFORD | | | | 2. Date of Death Month NOVEMBER Day 30 Year 1997 | | 3. Time of Death 2:59 pm | |
| | 4a. Facility Name (If not institution, give street and number) SINAI HOSPITAL | | | | 4b. City, Town, or Location of Death BALTIMORE | | 4c. County of Death na | |
| Funeral Director | 5. Social Security Number 227-56-1198 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 54 Yrs. | | 8. Date of Birth (Month, Day, Year) 7-6-1943 | |
| | 9. Birthplace (State or Foreign Country) Va | | 10a. State Md | | 10b. County NA | | 10c. City, Town or Location Baltimore | |
| To Be Completed by Funeral Director | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number 655 Charraway Road | | 10f. Zip Code 21229 | | 10g. Citizen of What Country? U.S.A | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Black | |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th grade | | College (1-4or 5+) NA | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Care Aid | | 16b. Kind of Business/Industry State of Md | |
| | 17. Father's Name (First, Middle, Last) Rudolph Wormley | | | | 18. Mother's Name (First, Middle, Maiden Surname) Margaret Christian | | | |
| Physician /Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) Fred Lunsford, Jr - Husband | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 655 Charraway Baltimore, Md 21229 | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Cedar Hill Cemetery | | 20c. Location - City or Town, State 12-6-97 Anne Arundel Co, Md | | 21. Signature of Funeral Service Licensee Solo March | |
| To Be Completed by Physician/Medical Examiner | 22. Name and Address of Facility MARCH FH.-4300 WABASH AVENUE, BALTO. | | | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. cardiac arrest | | | |
| | 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. S/P mitral valve replacement 7/97 | | | | 23c. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | |
| To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| To Be Completed by Physician/Medical Examiner | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | |
| To Be Completed by Physician/Medical Examiner | 29b. Signature and title of certifier Shelley N. ... | | 29c. License number 33024 | | 29d. Date signed (Month, Day, Year) 12/2/97 | | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) 7505 Oster Dr. Balt MD 21204 Shelley N. ... | |
| | 31. Date filed (Month, Day, Year) DEC 22 1997 | | 32. Registrar's Signature Julia ... | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

The first part of the report
 is devoted to a description of the
 general conditions of the
 country and the population.
 The second part is devoted to a
 description of the climate and the
 vegetation. The third part is devoted
 to a description of the animals and
 the plants. The fourth part is devoted
 to a description of the minerals and
 the fossils. The fifth part is devoted
 to a description of the history and
 the present state of the country.

The first part of the report
 is devoted to a description of the
 general conditions of the
 country and the population.
 The second part is devoted to a
 description of the climate and the
 vegetation. The third part is devoted
 to a description of the animals and
 the plants. The fourth part is devoted
 to a description of the minerals and
 the fossils. The fifth part is devoted
 to a description of the history and
 the present state of the country.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

JOSEPH BULLOCK LOCHNER

2. Date of Death

Month Day Year
DECEMBER 17, 1997

3. Time of Death

4:16 AM

4a. Facility Name (If not institution, give street and number)

Saint Joseph Medical Center

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

212-05-0952

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

80

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
January 15, 1917

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

521 Windwood Road

10f. Zip Code

21212

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - if Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Technician

16b. Kind of Business/Industry

Telephone

17. Father's Name (First, Middle, Last)

Joseph Anthony Lochner

18. Mother's Name (First, Middle, Maiden Surname)

Katherine Bullock

19a. Informant's Name/Relationship (Type, Print)

Doris M Lochner

Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

521 Windwood Road Baltimore, Maryland 21212

20a. Method of Disposition

2 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Moreland Memorial Park

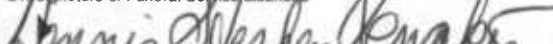
Date

12/20/97

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

Mitchell-Wiedefeld Home
6500 York Road Baltimore, Maryland 21212

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

PULMONARY EDEMA

Approximate Interval Between Onset and Death

< 24 HR.

e. Due to (or as a consequence of):

CARDIOPULMONARY ARREST

IMMED.

b. Due to (or as a consequence of):

PROBABLE ISCHEMIC HEART DISEASE

UNKNOWN

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and Title of Certifier



29c. License number

D 50361

29d. Date signed (Month, Day, Year)

12/17/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

MICHAEL P. GRANT, M.D., 7620 YORK ROAD, TOWSON, MD. 21204

31. Date filed (Month, Day, Year)

DEC 22 1997

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transfer permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

97 38565

DMMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38566

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Marian P. Murdock

2. Date of Death

December 20, 1997

3. Time of Death

3:05 am

4a. Facility Name (If not institution, give street and number)

Manor Care 6600 Ridge Rd.

4b. City, Town, or Location of Death

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

218-18-8687

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

89

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

4-12-1908

9. Birthplace (State or Foreign Country)

West Virginia

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6600 Ridge Road

10f. Zip Code

21237

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (14 or 5+)

8th

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Nurses Aide

16b. Kind of Business/Industry

City Hospital

17. Father's Name (First, Middle, Last)

Frank Chiodo

18. Mother's Name (First, Middle, Maiden Surname)

Carmela DeMassi

19a. Informant's Name/Relationship (Type, Print)

Carmela Higgins

daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

442 Margaret Ave., Baltimore, Maryland 21221

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Sacred Heart of Jesus

Date

12/23/97

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Joseph N. Zannino Jr.

22. Name and Address of Facility

Joseph N. Zannino Jr. Funeral Hm.

263 S. Conkling St. Baltimore, Maryland 21224

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

Urosepsis

Due to (or as a consequence of):

b.

Dementia

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Ischemic Dependent Lobes with
Hypertension
Cerebral Vascular Accident

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

N/A

28b. Time of Injury

N/A M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

N/A

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

N/A

28f. Location (Street and Number or Rural Route Number, City or Town, State)

N/A

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Robert S. Kurght MD

29c. License number

D38933

29d. Date signed (Month, Day, Year)

12/20/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Robert S. Kurght MD 104 Plantree Rd. Ste 102 Bel Air Md

31. Date filed (Month, Day, Year)

DEC 22 1997

32. Registrar's Signature

Julia Davidson-Randall

21015

State
Registrar

12-20-97 3:05 AM.
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

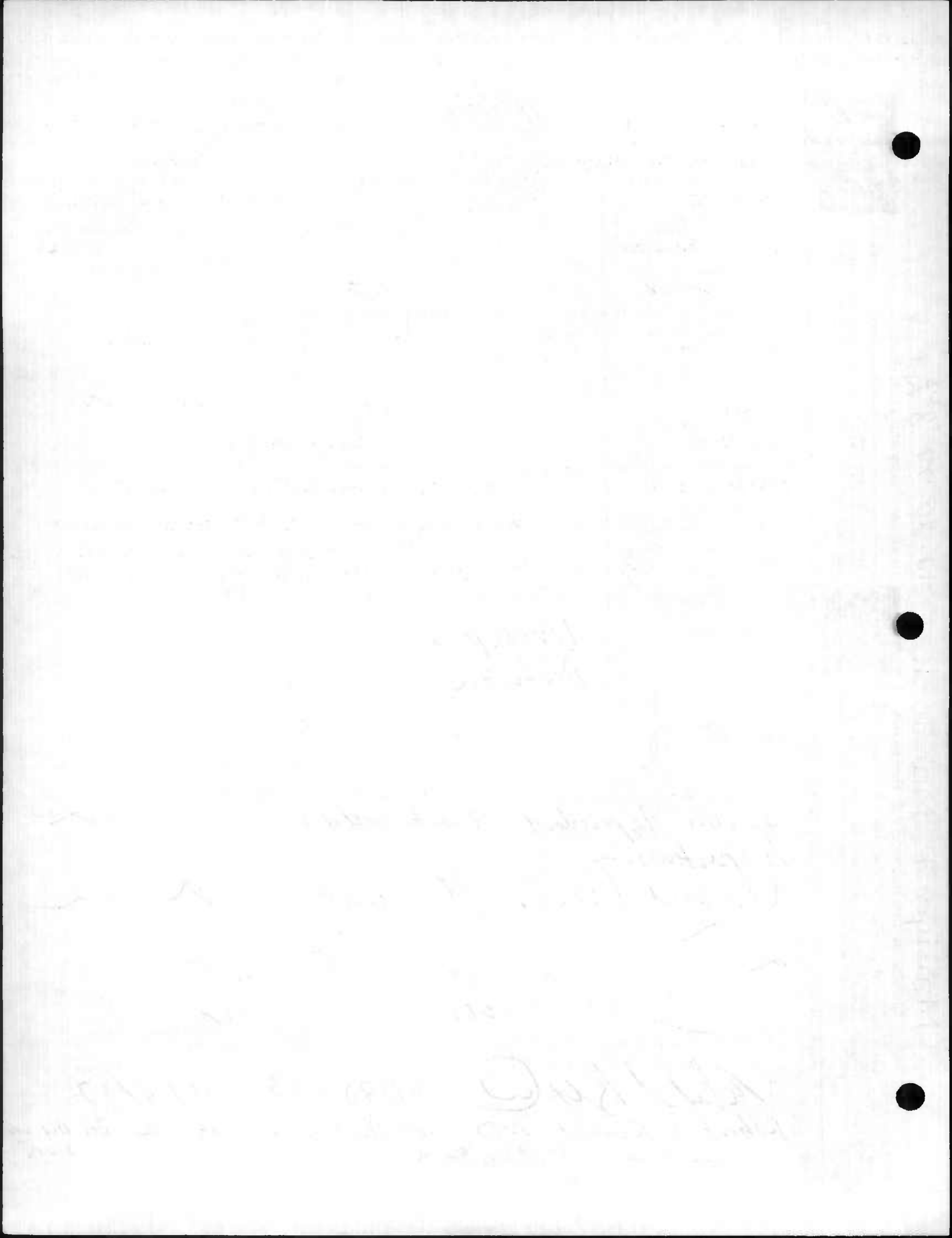
Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Marian P. Murdock, P.O. Box 68760, Division of Vital Records



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38567

Physician
/Medical
Examiner

Funeral
Director

1. Decedent's Name (First, Middle, Last)

Joan Mancuso

2. Date of Death

December 17 1997

3. Time of Death

0425

4a. Facility Name (If not institution, give street and number)

Johns Hopkins Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

5. Social Security Number

146-26-5873

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

66 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Oct. 24, 1931

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Dundalk

10d. Inside City Limits

1 ☐ Yes ☒ No

10e. Street and Number

7375 Edsworth Road

10f. Zip Code

21222

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12 Years

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Salesperson

16b. Kind of Business/Industry

Catalog Sales

17. Father's Name (First, Middle, Last)

Michael Francis Hayes

18. Mother's Name (First, Middle, Maiden Surname)

Helen Ellis

19a. Informant's Name/Relationship (Type, Print)

Mr. Michael D. Wise / Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7375 Edsworth Road Dundalk, Maryland 21222

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

St. Stanislaus Cemetery

Date

12/20/97

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

Duda-Ruck Funeral Home of Dundalk, Inc.

7922 Wise Ave. Dundalk, Maryland 21222

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Enter only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. MYOCARDIAL INFARCTION

Due to (or as a consequence of):

8 Hours

b. CORONARY ARTERY DISEASE

Due to (or as a consequence of):

40 YEARS

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home

5 ☐ Residence

6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Peter W. Cho MD, Chief Resident

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

12-17-97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Peter Cho, Johns Hopkins Hospital 600 North Wolfe Street Baltimore, Md. 21287

31. Date filed (Month, Day, Year)

DEC 22 1997

32. Registrar's Signature

J. Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 38568

Physician
/Medical
Examiner

Funeral
Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "Natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | | | | |
|--|--|---|--|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last) Cecelia MERLO | | | | 2. Date of Death Month December Day 17 Year 1997 | | 3. Time of Death 10:24 AM | |
| 4a. Facility Name (If not institution, give street and number) Laurel Regional Hospital | | | | 4b. City, Town, or Location of Death Laurel | | 4c. County of Death Prince George | |
| 5. Social Security Number 222-26-3249 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 55 Yrs. | | 8. Date of Birth (Month, Day, Year) Aug 08, 1942 | |
| 9. Birthplace (State or Foreign Country) Delaware | | 10a. State MD | | 10b. County Howard | | 10c. City, Town or Location Jessup | |
| 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number 8311 Ashwood Road | | 10f. Zip Code 20794 | | 10g. Citizen of What Country? USA | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Service Assistant | | 16b. Kind of Business/Industry Insurance Company | | 17. Father's Name (First, Middle, Last) Clifford Grant Chapman | |
| 18. Mother's Name (First, Middle, Maiden Surname) Helen Marie Blizzard | | 19a. Informant's Name/Relationship (Type, Print) Joseph Merlo/spouse | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 1175, Jessup, Maryland 20794 | | 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | |
| 20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory, Inc. | | 20c. Date 12/20 | | 20d. Location - City or Town, State Catonsville, Maryland | | 21. Signature of Funeral Service Licensee | |
| 22. Name and Address of Facility Donaldson Funeral Home, P.A. | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Acute MYOCARDIAL INFARCTION Due to (or as a consequence of): | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown | | 23c. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 23d. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | 24a. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. BRONCHIECTASIS CHRONIC Obstructive Lung Disease | | 24b. Location (Street and Number or Rural Route Number, City or Town, State) | | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | |
| 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | |
| 29b. Signature and title of certifier | | 29c. License number D13916 | | 29d. Date signed (Month, Day, Year) December 18, 1997 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) William A Warren 321 Prince George St Laurel, MD 20707 | |
| 31. Date filed (Month, Day, Year) DEC 22 1997 | | 32. Registrar's Signature | | 33. Registrar's Name John Davidson-Randall | | 34. Registrar's Title Registrar | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38569

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Mack

McGraw

2. Date of Death

Month Day Year
December 18, 1997

3. Time of Death

0120

4a. Facility Name (If not institution, give street and number)

The Johns Hopkin Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

n/a

Funeral
Director

5. Social Security Number

070-18-7284

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

81 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

June 10, 1916

9. Birthplace (State or Foreign Country)

SC

Usual Residence of Decedent

10a. State

MD

10b. County

n/a

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

926 Newington Ave.

10f. Zip Code

21217

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

7th

College (1-4 or 5+)

16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Assembly Line

16b. Kind of Business/Industry

Eastern Can Co.

17. Father's Name (First, Middle, Last)

Ross McGraw

18. Mother's Name (First, Middle, Maiden Surname)

Anna Smart

19a. Informant's Name/Relationship (Type, Print)

Michael McGraw/son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5307 Rio Plata Dr. Oceanside, CA 92057

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Maryland National

Date

12/23

20c. Location - City or Town, State

Laurel, MD

21. Signature of Funeral Service Licensee

James A. Morton

22. Name and Address of Facility

James A. Morton & Sons Funeral Home
1701 Laurens St. BALTO., MD 21217

23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Sepsis
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 week

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Gastric Cancer
Due to (or as a consequence of):

8 months

c. malnutrition
Due to (or as a consequence of):

8 months

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☒ Inpatient

☐ ER/Outpatient

☐ DOA

Other:

☐ Nursing Home

☐ Residence

☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending Investigation
☐ Accident ☐ Could not be determined
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

James A. Morton

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

December 18, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Johns Hopkins Hospital, Baltimore, Maryland

31. Date filed (Month, Day, Year)

DEC 22 1997

32. Registrar's Signature

John A. Randall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be distributed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **97 38570**
Certificate of Death

Reg. No.

Physician
/Medical
ExaminerFuneral
Director

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. Decedent's Name (First, Middle, Last) BRIANNA JOVELSA MINOR | | | | 2. Date of Death Month DEC Day 15 Year 1997 | | 3. Time of Death 3:42 PM | |
| 4a. Facility Name (If not institution, give street and number) NATIONAL NAVAL MEDICAL CENTER | | | | 4b. City, Town, or Location of Death BETHESDA | | 4c. County of Death MONTGOMERY | |
| 5. Social Security Number N/A | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) Yrs. 6 | | 8. Date of Birth (Month, Day, Year) Dec 9, 1997 | |
| 9. Birthplace (State or Foreign Country) Virginia | | 10a. Usual Residence of Decedent | | 10b. State VA | | 10c. City, Town or Location Prince William | |
| 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 10e. Street and Number 15724 Edgewood Drive | | 10f. Zip Code 22026 | | 10g. Citizen of What Country? United States | |
| 11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Black | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 0 College (1-4 or 5+) 0 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Infant | | 16b. Kind of Business/Industry Infant | | 17. Father's Name (First, Middle, Last) Phillip Minor | |
| 18. Mother's Name (First, Middle, Maiden Surname) Colaine D. Jordan | | 19a. Informant's Name/Relationship (Type, Print) Phillip Minor/Father | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15724 Edgewood Drive, Dumfries, VA 22026 | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Quantico National Cemetery | | 20c. Date 12/22 | | 20d. Location - City or Town, State Quantico, VA | |
| 21. Signature of Funeral Service Licensee  | | 22. Name and Address of Facility Fleck Funeral Home, Inc. 7601 Sandy Spring Rd. Laurel, MD 20707 | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. MECONIUM ASPIRATION | | Approximate Interval Between Onset and Death | |
| 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | 23c. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) DEC 22 1997 | |
| 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier J. R. GREENWALD, CDR, MC, USNR | | 29c. License number MD D - 44634 | |
| 29d. Date signed (Month, Day, Year) 18 Dec 97 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NATIONAL NAVAL MEDICAL CENTER BETHESDA MD 20889-5600 | | 31. Date filed (Month, Day, Year) DEC 22 1997 | | 32. Registrar's Signature  | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

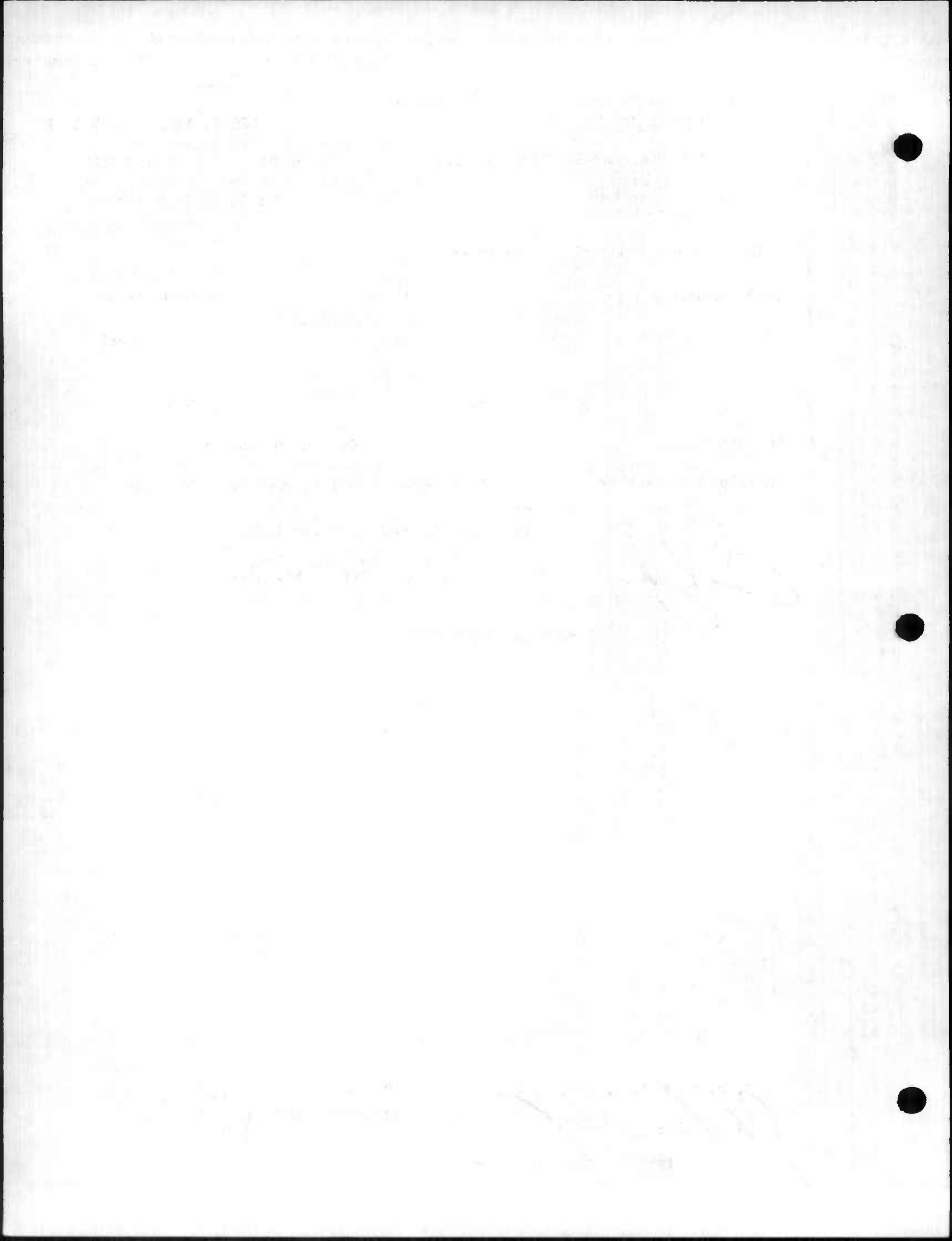
Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

3

State
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

37 38571

| | | | | | | | | |
|--|---|--|---|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Richard Wayne Nebinger | | | | 2. Date of Death Month Day Year December 17, 1997 | | 3. Time of Death 10:30 AM | |
| | 4a. Facility Name (If not institution, give street and number) 1928 Queens Way | | | | 4b. City, Town, or Location of Death Dundalk | | 4c. County of Death Baltimore | |
| Funeral Director | 5. Social Security Number 213-07-1597 | | 6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 93 Yrs. | | 8. Date of Birth (Month, Day, Year) Jan. 27, 1904 | |
| | 9. Birthplace (State or Foreign Country) Pennsylvania | | 10a. State Maryland | | 10b. County Baltimore | | 10c. City, Town or Location Dundalk | |
| To Be Completed by Funeral Director | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 10e. Street and Number 1928 Queens Way | | 10f. Zip Code 21222 | | 10g. Citizen of What Country? United States | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Years | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Draftman | | 16b. Kind of Business/Industry Steel Industry | | | |
| | 17. Father's Name (First, Middle, Last) Ralph Sigmund Nebinger | | | | 18. Mother's Name (First, Middle, Maiden Surname) Edna Alverna Billet | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Debra Zimmerman/Daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7430 Old Battle Grove Road Dundalk, MD 21222 | | | |
| | 20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Hilltop Service Corp. | | 20c. Location - City or Town, State Towson, Maryland | | 20d. Date 12/20/1997 | |
| | 21. Signature of Funeral Service Licensee <i>Patricia M. Fleming</i> | | | | 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <i>Possible Auto M1</i> | | | | | | | |
| | 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| | 23c. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | | | | | |
| 23d. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | |
| 23e. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | |
| 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| 29b. Signature and title of certifier <i>[Signature]</i> | | | | 29c. License number D14221 | | 29d. Date signed (Month, Day, Year) 12.17.97 | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <i>T. L. Brown, 223 E. Blvd, Balt Md 21221</i> | | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 22 1997 | | | | | | | | |
| 32. Registrar's Signature <i>[Signature]</i> | | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97-38572

Replacement

Physician
/Medical
Examiner

Funeral
Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | | | | |
|---|--|---|--|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last) <i>Lolita Nolder</i> | | | | 2. Date of Death Month <i>December</i> Day <i>8</i> Year <i>1997</i> | | 3. Time of Death <i>11:00 PM</i> | |
| 4a. Facility Name (If not institution, give street and number) SAINT JOSEPH MEDICAL CENTER | | | | 4b. City, Town, or Location of Death <i>Towson</i> | | 4c. County of Death <i>Baltimore</i> | |
| 5. Social Security Number 215-28-2699 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) <i>67</i> Yrs. | | 8. Date of Birth (Month, Day, Year) <i>11-22-30</i> | |
| 9. Birthplace (State or Foreign Country) PENNSYLVANIA | | 10a. State <i>MD</i> | | 10b. County <i>Baltimore</i> | | 10c. City, Town or Location BALTIMORE COUNTY | |
| 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number <i>908 Morris Ave</i> | | 10f. Zip Code <i>21093</i> | | 10g. Citizen of What Country? <i>USA</i> | |
| 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: <i>WHITE</i> | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+) <i>2</i> | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) EXECUTIVE SECRETARY | | 16b. Kind of Business/Industry MANUFACTURING | | | |
| 17. Father's Name (First, Middle, Last) HAROLD NOLDER | | | | 18. Mother's Name (First, Middle, Maiden Surname) RHODA LAVINA FRYER | | | |
| 19a. Informant's Name/Relationship (Type, Print) PAUL NOLDER/ BROTHER | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8511 WILLOW OAK, BALTIMORE, MARYLAND 21234 | | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) | | 20c. Location - City or Town, State | | | |
| 21. Signature of Funeral Service Licensee RONALD S. WADE, DIRECTOR | | | | 22. Name and Address of Facility STATE ANATOMY BOARD 655 W. BALTIMORE ST. BALTIMORE, MD. 21201 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <div style="display: flex;"> <div style="flex: 1;"> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last</p> </div> <div style="flex: 2;"> <p>a. <i>Ventricular Fibrillation</i> Due to (or as a consequence of):</p> <p>b. <i>New & Remote Coronary Occlusions</i> Due to (or as a consequence of):</p> <p>c. <i>Arteriosclerotic Cardiovascular Disease</i> Due to (or as a consequence of):</p> <p>d.</p> </div> </div> | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | |
| | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 28. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 26a. Date of Injury (Month, Day Year) | | 26b. Time of Injury <i>M</i> | | 26c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | | 26d. Describe how injury occurred | | 26e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 26f. Location (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| 29b. Signature and title of certifier <i>Charles F. O'Donnell MD</i> | | 29c. License number <i>D-09383</i> | | 29d. Date signed (Month, Day, Year) <i>December 8, 1997</i> | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Charles F. O'Donnell MD - 111 Hamlet Hill Rd Baltimore Maryland 21210</i> | | | | | | | |
| 31. Date filed (Month, Day, Year) FEB 11 1998 | | 32. Registrar's Signature <i>Julia Burden-Rendell</i> | | | | | |

17-1

[Faint, illegible text covering the majority of the page, likely bleed-through from the reverse side.]

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38573

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

FLORENCE W. NACHAMKIN

2. Date of Death

Month Day Year
December 14, 1997

3. Time of Death

11:07 PM

4a. Facility Name (If not institution, give street and number)

Suburban Hospital

4b. City, Town, or Location of Death

Bethesda

4c. County of Death

Montgomery

5. Social Security Number

121-03-5269

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

84 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
April 18, 1913

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Rockville

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

6111 Montrose Road, Apt. 501

10f. Zip Code

20852

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2+ Years

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Jacob Wolfson

18. Mother's Name (First, Middle, Maiden Surname)

Jennie Flax

19a. Informant's Name/Relationship (Type, Print)

Cindy Soffrin, Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

14955 Duffief Drive, Gaithersburg, Maryland 20878

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Mount Lebanon Cemetery

Date

12/16/1997

20c. Location - City or Town, State

Adelphi, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

STEIN HEBREW MEMORIAL FUNERAL HOME, INC.

232 CARROLL STREET, NW, WASHINGTON, DC 20012

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. CONGESTIVE HEART FAILURE

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

METASTATIC BREAST CANCER

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D20367

29d. Date signed (Month, Day, Year)

12/15/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Joel P. Kalman, M.D., 6111 Executive Blvd., Rockville, MD 20852-3976

31. Date filed (Month, Day, Year)

DEC 22 1997

32. Registrar's Signature

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38574

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Raleigh E. Pierce

2. Date of Death

Month Day Year
December 20 1997

3. Time of Death

9:40 PM

4a. Facility Name (If not institution, give street and number)

3 Eugene Avenue

4b. City, Town, or Location of Death

Essex

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

213-01-3410

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

87 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

May 27, 1910

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Essex

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10a. Street and Number

3 Eugene Avenue

10f. Zip Code

21221

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8

Collage (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Shop Foreman

16b. Kind of Business/Industry

Foundry

17. Father's Name (First, Middle, Last)

Claude W. Pierce

18. Mother's Name (First, Middle, Maiden Summa)

Adina Williams

19a. Informant's Name/Relationship (Type, Print)

Mason Lynn Pierce (DAUGHTER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 33060
331 South East 19th Avenue Apt. 4 Pompano Beach, Fla.

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Meadowridge Cemetery 12/23/1997

Date

20c. Location - City or Town, State

Elkridge, Md.

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

Bruzdinski Funeral Home P.A.
1407 Old Eastern Avenue Essex, Md. 21221

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Coronary Artery Disease
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Cerebrovascular Disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and Title of certifier

[Signature]

29c. License number

221242

29d. Date signed (Month, Day, Year)

Dec 22, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

1245 Eastern Blvd Balto, Md 21221

31. Date filed (Month, Day, Year)

DEC 22 1997

32. Registrar's Signature

[Signature]

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38575

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

SALLY SWISS PERLBERG

2. Date of Death
Month Day Year

December 15, 1997

3. Time of Death

8:13 AM

4a. Facility Name (If not institution, give street and number)

Holy Cross Hospital

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

216-50-9816

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

80

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth
(Month, Day, Year)

Oct. 9, 1917

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

11015 Burnley Terrace

10f. Zip Code

20902

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced12. Was Decedent Ever In U.S.
Armed Forces?1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12 Years

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Philip I. Swiss

18. Mother's Name (First, Middle, Maiden Surname)

Fannie Olshinka

19a. Informant's Name/Relationship (Type, Print)

Morris Perlberg, Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11015 Burnley Terrace, Silver Spring, Maryland 20902

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

King David Memorial Garden

Date

12/16/1997

20c. Location - City or Town, State

Falls Church, Virginia

21. Signature of Funeral Service Licensee

Allen Smith

m00544

22. Name and Address of Facility

STEIN HEBREW MEMORIAL FUNERAL HOME, INC.

232 CARROLL STREET, N.W., WASHINGTON, DC 20012

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)a. ADENOCARCINOMA OF THE OVARY
Due to (or as a consequence of):
WITH METASTASISSequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Lastb. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.Approximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
2 ☐ Accident investigation
3 ☐ Suicide 6 ☐ Could not be
4 ☐ Homicide determined28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury at
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Mark H. Eig

29c. License number

D24886

29d. Date signed (Month, Day, Year)

December 15, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mark H. Eig, M.D., 10801 Lockwood Drive, Suite 280, Silver Spring, Maryland 20901

31. Date filed (Month, Day, Year)

DEC 22 1997

32. Registrar's Signature

Julia Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38576

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

BEATRICE PATRICIA REISLER

2. Date of Death

Month 12 Day 21 Year 1997

3. Time of Death

10:40 pm

4a. Facility Name (If not institution, give street and number)

UNION MEMORIAL HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

216-16-6806

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

76 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year) APRIL 15 1921

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10e. State

MARYLAND

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3530 GREENMOUNT AVENUE

10f. Zip Code

21218

10g. Citizen of What Country?

UNITED STATES

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: WHITE

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16e. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

HOMEMAKER

16f. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

LAWRENCE SHELDON BRUNS

18. Mother's Name (First, Middle, Maiden Surname)

MARY TERESA AFFAYROUX

19e. Informant's Name/Relationship (Type, Print)

ANNE D. BRUNS / SISTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3532 GREENMOUNT AVENUE BALTIMORE, MARYLAND 21218

20e. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

PARKWOOD CEMETERY

Date

12-24-97

20c. Location - City or Town, State

BALTIMORE, MARYLAND

21. Signature of Funeral Service Licensee

Steven T. Zeller

22. Name and Address of Facility

MITCHELL-WIEDEFELD HOME
6500 YORK ROAD BALTIMORE, MARYLAND 2121223a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

e. Pneumonia

Due to (or as a consequence of):

b. Chronic myelocytic leukemia

Due to (or as a consequence of):

c. Urinary Tract Infection

Due to (or as a consequence of):

d.

Approximate
Interval Between
Onset and Death

One wk

4 years

10 days

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown24e. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29e. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Hilary R. Woodson, MD

29c. License number

AU41766 435W9386

29d. Date signed (Month, Day, Year)

December 21, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

29 S. Pace St, Baltimore, MD 21201

31. Date filed (Month, Day, Year)

DEC 22 1997

32. Registrar's Signature

Julia Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38577

| | | | | | | | | | |
|---|---|--|--|--|--|--|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Harry Tome Rorabaugh | | | | 2. Date of Death Month December Day 17, 1997 Year | | 3. Time of Death 6:30 pm | | |
| | 4a. Facility Name (If not institution, give street and number) Lorien Nursing Home | | | | 4b. City, Town, or Location of Death Columbia | | 4c. County of Death Howard | | |
| Funeral Director | 5. Social Security Number 213-05-8236 | | 6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 92 Yrs. | | 8. Date of Birth (Month, Day, Year) Sept 15, 1905 | | |
| | 9. Birthplace (State or Foreign Country) Virginia | | 10a. State MD | | 10b. County Howard | | 10c. City, Town or Location Columbia | | |
| Usual Residence of Decedent | | 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 10e. Street and Number 6336 Cedar Lane #241 | | 10f. Zip Code 21044 | | 10g. Citizen of What Country? USA | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Grade 12 College (1-4 or 5+) College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Accountant | | 16b. Kind of Business/Industry Chemical Co. | | 17. Father's Name (First, Middle, Last) Charles Rorabaugh | | 18. Mother's Name (First, Middle, Maiden Surname) Lillian Bibb | |
| 19a. Informant's Name/Relationship (Type, Print) Dorothy Zachmann/daughter | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3812 Grosvenor Drive, Ellicott City, MD 21042 | | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Savage Cemetery | | 20c. Date 12/20 | |
| 20d. Location - City or Town, State Savage, Maryland | | 21. Signature of Funeral Service Licensee | | 22. Name and Address of Facility Donaldson Funeral Home, P.A. 313 Talbott Ave. Laurel, Maryland 20707-4389 | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. a. Dementia Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | Approximate interval Between Onset and Death 3 years | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | |
| 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier William Flowers MD | | 29c. License number D 20789 | | 29d. Date signed (Month, Day, Year) | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) William Flowers MD 1055 Little Patuxent Columbia MD | | 31. Date filed (Month, Day, Year) DEC 22 1997 | | 32. Registrar's Signature John Davidson-Randall | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Item: 31 Per RC Film G-754 12-22-97RC

Certificate of Death

Reg. No.

37 38578

Edward Reed

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Physician / Medical Examiner

Funeral Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | | | | | | |
|---|--|---|--|--|--|---|---|--|--|
| 1. Decedent's Name (First, Middle, Last) Edward Charles Reed, Sr. | | | | 2. Date of Death Month Day Year DECEMBER 19 1997 12:30am | | | | 3. Time of Death 12:30am | |
| 4a. Facility Name (If not institution, give street and number) GREATER BALTIMORE MEDICAL CENTER | | | | 4b. City, Town, or Location of Death TOWSON | | | | 4c. County of Death BALTIMORE | |
| 5. Social Security Number 218-26-1633 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 67 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) Oct. 1, 1930 | | 9. Birthplace (State or Foreign Country) Maryland | |
| Usual Residence of Decedent | | | | | | | | | |
| 10a. State Md. | | 10b. County Baltimore | | 10c. City, Town or Location Owings Mills | | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10e. Street and Number 106 S. Ritters Lane | | | | 10f. Zip Code 21117 | | 10g. Citizen of What Country? U.S.A. | | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1949-1950 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) Fireman | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Fireman | | | 16b. Kind of Business/Industry Baltimore Co. Fire Dp. | | |
| 17. Father's Name (First, Middle, Last) Edward Leroy Reed | | | | 18. Mother's Name (First, Middle, Maiden Surname) Ethel Kaylor | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Betty Reed | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 106 S. Ritters Lane, Owings Mills, Md. 21117 | | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Lake View Mem. Park Dec. 29, 1997 | | Date 29, 1997 | | 20c. Location - City or Town, State Sykesville, Md. | | | |
| 21. Signature of Funeral Service Licensee <i>H. J. Schlander</i> | | | | 22. Name and Address of Facility Eckhardt Funeral Chapel 11605 Reisterstown Rd., Owings Mills, Md. 21117 | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Cardio Resp arrest. Due to (or as a consequence of): Septic shock Due to (or as a consequence of): Colon Ischaemia + Perforation Due to (or as a consequence of): Large Supracardiac Aneurysm Rupture Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. / | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Certifying Physician: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | |
| 29b. Signature and Title of certifier <i>[Signature]</i> | | | | 29c. License number D27064 | | 29d. Date signed (Month, Day, Year) 12/20/97 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) R. V. RAJAKAR 6801 Belair Road Baltimore 21206 MD | | | | | | | | | |
| 31. Date filed (Month, Day, Year) 12/20/97 | | 32. Registrar's Signature <i>Julia Davidson-Randall</i> DEC 22 1997 | | | | | | | |

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• *Journal of Management Education* 25(10):1139-1150

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0702-1012

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• 01, 11/11/2011, 10:00 AM

100-100000 100000

1107 1st Avenue, N.E., Chicago, Ill., U.S.A.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38579

| | | | | | | | | |
|---|--|--|---|-------------------------------|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Marjorie Rohde | | | | 2. Date of Death Month Day Year Dec 18 1997 | | 3. Time of Death 06:15 AM | |
| | 4a. Facility Name (If not institution, give street and number) St. Agnes Hospital | | | | 4b. City, Town, or Location of Death Baltimore | | 4c. County of Death n/a | |
| Funeral Director | 5. Social Security Number 217-36-4823 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 59 Yrs. | | 8. Date of Birth (Month, Day, Year) May 31, 1938 | |
| | 9. Birthplace (State or Foreign Country) Maryland | | 10a. State Maryland | | 10b. County Baltimore | | 10c. City, Town or Location Baltimore | |
| To Be Completed by Funeral Director | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 10e. Street and Number 329 Westshire Boulevard | | 10f. Zip Code 21229 | | 10g. Citizen of What Country? USA | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: white | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) legal secretary | | 16b. Kind of Business/Industry attorney at law | | | |
| | 17. Father's Name (First, Middle, Last) John Hanna | | | | 18. Mother's Name (First, Middle, Maiden Surname) Alice (unknown) | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Mr. Richard J. Kinlein/personal rep. | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8355 Court Ave., Ellicott City, MD 21043 | | | |
| | 20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory | | 20c. Location - City or Town, State Catonsville, Maryland | | 20d. Date 12-19-97 | |
| | 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility Slack Funeral Home, P.A. M00535 Ellicott City, Maryland 21043 | | | |
| | 23a. Pertinent disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Acute Anterior Myocardial Infarction 4 days Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Schizophrenia | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | | | | | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | |
| To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once. | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| | 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| State Registrar | 29b. Signature and title of certifier | | | | 29c. License number D46704 | | 29d. Date signed (Month, Day, Year) Dec 18, 1997 | |
| | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) MUTOMBO KANKONDE, ST AGNES HOSPITAL BLT MD | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 22 1997 | | | | 32. Registrar's Signature | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 38580

Item:8 per FH G-754 12/30/97 dh

Physician
/Medical
Examiner

Funeral
Director

| | | | | | |
|--|---------------------------------|---|---|--|--|
| 1. Decedent's Name (First, Middle, Last) James Franklin Stone | | 2. Date of Death Month December Day 22 Year 1997 | | 3. Time of Death 7:30 AM | |
| 4a. Facility Name (If not institution, give street and number) 1738 Bayard Ave. | | | 4b. City, Town, or Location of Death Dundalk | | 4c. County of Death Baltimore |
| 5. Social Security Number 216-01-5236 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 84 Yrs. | 8. Date of Birth (Month, Day, Year) July 23 1913 | |
| 9. Birthplace (State or Foreign Country) S. Carolina | | 10. Usual Residence of Decedent | | | |
| 10a. State MD | 10b. County Baltimore | 10c. City, Town or Location Dundalk | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10e. Street and Number 1738 Bayard Ave. | | 10f. Zip Code 21222 | | 10g. Citizen of What Country? USA | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | |
| 14. Race - American Indian, Black, White, etc. Specify: White | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9 College (1-4or 5+) | | | |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Pipefitter | | 16b. Kind of Business/Industry General Motors | | | |
| 17. Father's Name (First, Middle, Last) James Franklin Stone | | | 18. Mother's Name (First, Middle, Maiden Surname) Mary Cross | | |
| 19a. Informant's Name/Relationship (Type, Print) John Stone / son | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1738 Bayard Ave Baltimore, MD 21222 | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Sacred Heart of Jesus | | 20c. Location - City or Town, State 1997 Baltimore, MD | |
| 21. Signature of Funeral Service Licensee Anthony C. Connolly | | | 22. Name and Address of Facility Connolly Funeral Home of Dundalk 7110 Sollers Point Rd 21222 | | |
| 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Cancer of Colon with Mets to Com A Due to (or as a consequence of): b. Ascites Due to Cancer Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | Approximate Interval Between Onset and Death Cancer 72 hr Comp 1 day |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | 28b. Time of Injury M | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | 28d. Describe how injury occurred |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | |
| 29b. Signature and title of certifier [Signature] | | 29c. License number D14221 | | 29d. Date signed (Month, Day, Year) 12.22.97 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Tarique A. Firozvi, M.D. 223 Eastern Blvd. Baltimore, MD 21221 | | | | | |
| 31. Date filed (Month, Day, Year) DEC 22 1997 | | 32. Registrar's Signature [Signature] | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be completed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 38581

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|---|---|---|-----------------------------------|---|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) ANN RITA SEMONE | | | | 2. Date of Death Month Day Year December 16, 1997 | | 3. Time of Death 6:00 P.M. | |
| | 4a. Facility Name (If not institution, give street and number) Homewood | | | | 4b. City, Town, or Location of Death Baltimore | | 4c. County of Death N/A | |
| Funeral Director | 5. Social Security Number 218-07-4821 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 80 Yrs. | | 8. Date of Birth (Month, Day, Year) Nov. 7, 1917 | |
| | Usual Residence of Decedent 10a. State Maryland | | 10b. County N/A | | 10c. City, Town or Location Baltimore | | 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| To Be Completed by Funeral Director | 10e. Street and Number 6000 Bellona Avenue | | | | 10f. Zip Code 21212 | | 10g. Citizen of What Country? U.S.A. | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 years | | College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Sales | | 16b. Kind of Business/Industry Retail | |
| | 17. Father's Name (First, Middle, Last) Francis Barry Hennegan | | | | 18. Mother's Name (First, Middle, Maiden Surname) Ann Neary | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Patrick Semone (son) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6920 Donachie Road Baltimore, Maryland 21239 | | | |
| | 20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Green Mount Crematory | | Data 12-19-97 | | 20c. Location - City or Town, State Baltimore, Maryland | |
| | 21. Signature of Funeral Service Licensee <i>George Ferrante</i> | | | | 22. Name and Address of Facility Mitchell-Wiedefeld Home 6500 York Road Baltimore, Maryland 21212 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>Cerebral Thrombosis</i> Due to (or as a consequence of): b. <i>Cerebrovascular Disease</i> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | |
| | Approximate interval Between Onset and Death <i>4 years</i> | | | | | | | |
| | Physician /Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Dementia of Alzheimer Type</i> <i>Diabetes mellitus</i> | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |
| | | | | | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 28. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| | | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) | | 28d. Describe how injury occurred | | | | |
| | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier <i>Walter R Welzant MD</i> | | | | 29c. License number D 12039 | | 29d. Date signed (Month, Day, Year) DEC 18, 1997 | | |
| 30. Name and address of person who completed cause of death (item 23e) (Type, Print) WALTER R WELZANT MD 7600 OSLER DR STE 107 towson 21204 | | | | | | | | |
| State Registrar | 31. Date filed (Month, Day, Year) DEC 22 1997 | | | | 32. Registrar's Signature <i>Julia Davidson-Randall</i> | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transfer certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38582

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Mary

Backer

Smith

2. Date of Death
Month

December

Day

18,

Year

1997

3. Time of Death

8:20 p.m.

Funeral
Director

4e. Facility Name (If not institution, give street and number)

BROADMEAD

4b. City, Town, or Location of Death

Cockeysville

4c. County of Death

Baltimore

5. Social Security Number

214-40-5771

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

100 Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth
(Month, Day, Year)

Jan 26, 1897

9. Birthplace (State or Foreign
Country)

Ohio

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore County

10c. City, Town or Location

Cockeysville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

13801 York Road

10f. Zip Code

21030

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced12. Was Decedent Ever in U.S.
Armed Forces?1 ☐ Yes 2 ☒ NoIf Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Librarian

16b. Kind of Business/Industry

Library
Enoch Pratt Free Libr

17. Father's Name (First, Middle, Last)

Matthew Jackson Askew

18. Mother's Name (First, Middle, Maiden Summa)

Martha Goldsborough Henry

19a. Informant's Name/Relationship (Type, Print)

John M. Backer (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

402 Cedarcroft Road, Baltimore, MD 21212

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Loudon Park Cemetery

Date

12/20/97

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Martin D. Lawson

22. Name and Address of Facility

Mitchell-Wiedefeld Home

6500 York Road, Baltimore, Maryland 21212

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a.

STROKE

Due to (or as a consequence of):

b.

HYPERTENSION

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Sequentially list conditions,
if any, leading to immediate
cause. Enter underlying
Cause (Disease or injury
that initiated events
resulting in death) LastApproximate
Interval Between
Onset and Death

4 days

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ANGINA

COPD

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?N/A
1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending
Investigation6 ☐ Could not be
determined28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No28a. Place of Injury - At home, farm, street, factory, office,
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Barbara Carroll, MD

29c. License number

D38392

29d. Date signed (Month, Day, Year)

12/19/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BARBARA CARROLL, M.D. 13801 YORK RD, COCKEYSVILLE

31. Date filed (Month, Day, Year)

DEC 22 1997

32. Registrar's Signature

John Jackson

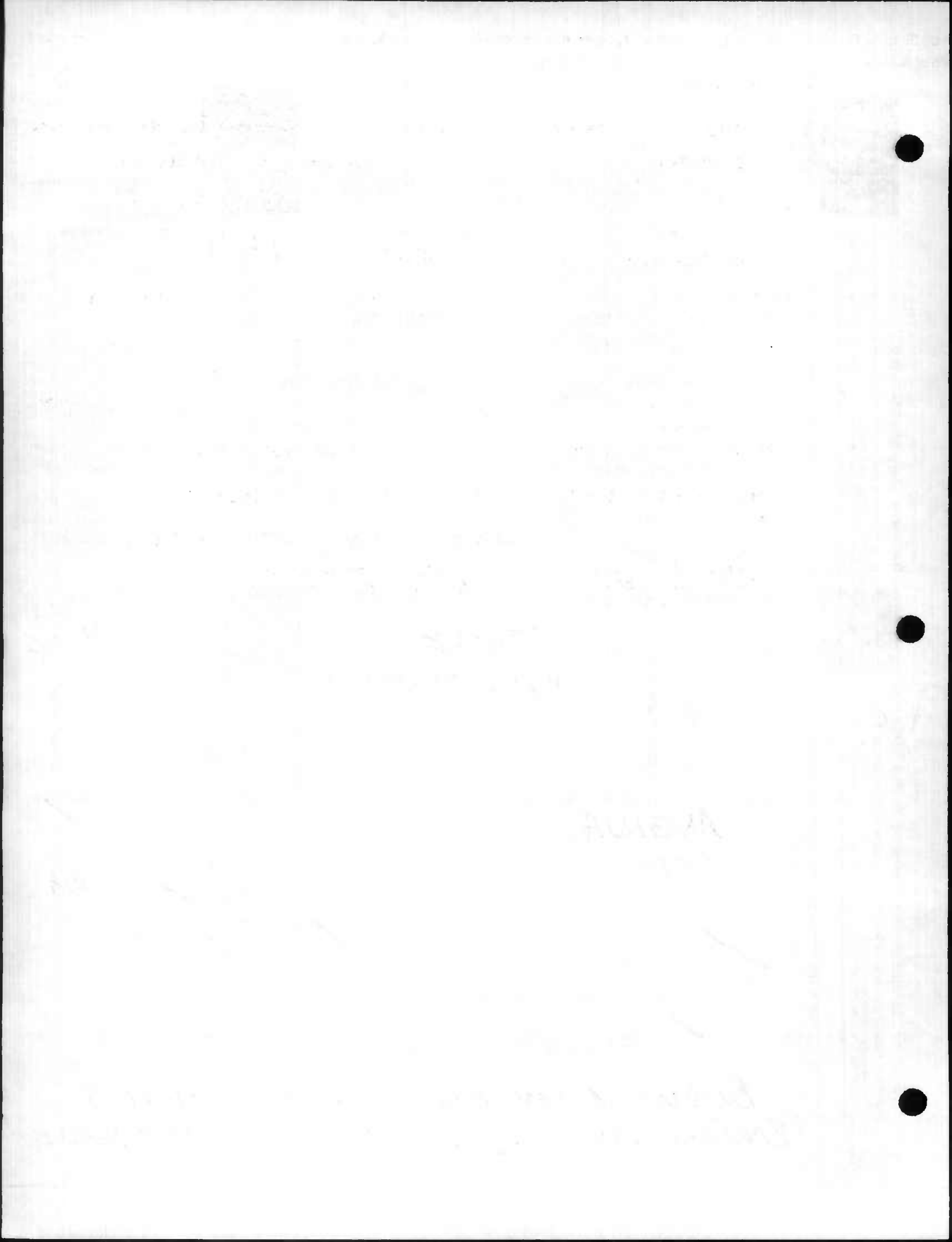
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "Natural", or item 23a or 23a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38583

Physician
/Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

| | | | | | | | |
|---|--|---|--|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last) JOSEPH SWANN, JR | | | | 2. Date of Death Month Day Year DECEMBER 14, 1997 | | 3. Time of Death 9:02 P | |
| 4a. Facility Name (If not institution, give street and number) 1800 BLK. ABBOTTSTON AVE. | | | | 4b. City, Town, or Location of Death BALTIMORE | | 4c. County of Death | |
| 5. Social Security Number 220-90-5080 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 19 Yrs. | | 8. Date of Birth (Month, Day, Year) 3-20-1978 | |
| 9. Birthplace (State or Foreign Country) Md | | 10. Usual Residence of Decedent | | | | | |
| 10a. State Md | | 10b. County N/A | | 10c. City, Town or Location Baltimore | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10e. Street and Number 2813 Kennedy Avenue | | | | 10f. Zip Code 21218 | | 10g. Citizen of What Country? U S A | |
| 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Black | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9th grade College (1-4 or 5+) N/A | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Unemployed | | 16b. Kind of Business/Industry N/A | |
| 17. Father's Name (First, Middle, Last) Joseph Swann, Sr | | | | 18. Mother's Name (First, Middle, Maiden Surname) Katrina Williams | | | |
| 19a. Informant's Name/Relationship (Type, Print) Katrina Williams- Mother | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2813 Kennedy Avenue Baltimore, Md 21218 | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Arbutus Memorial Park | | 20c. Date 12/20/97 | | 20d. Location - City or Town, State Arbutus, Md | |
| 21. Signature of Funeral Service Licensee <i>John B. Johnson</i> | | | | 22. Name and Address of Facility March F/H West 4300 Wabash Avenue Baltimore, Md 21215 | | | |

| | | | |
|--|--|--|--|
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Multiple Gun Shot Wounds Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | Approximate Interval Between Onset and Death | |
|--|--|--|--|

| | | | |
|--|--|--|--|
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| | | 24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| | | 24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |

| | | | |
|--|--|---|--|
| 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) ALLEY | |
| 27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) 12-14-97 | |
| | | 28b. Time of Injury 2057 M | |
| | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | | 28d. Describe how Injury occurred Subject Shot | |
| | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) 1800 BLK ABBOTTSTON AVE | |

| | | | |
|--|--|---|--|
| 29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier <i>John B. Johnson</i> | |
| | | 29c. License number OCME | |
| | | 29d. Date signed (Month, Day, Year) DECEMBER 15, 1997 | |

| | |
|---|--|
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dw. R Fowler 111 Penn Street, Baltimore, Maryland 21201 | |
|---|--|

| | | | |
|--|--|---|--|
| 31. Date filed (Month, Day, Year) DEC 22 1997 | | 32. Registrar's Signature <i>John Davidson-Randall</i> | |
|--|--|---|--|

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be completed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38584

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

David Lee Sloan Sr.

2. Date of Death

Month Day Year
December 19, 1997

3. Time of Death

7:40 PM

4a. Facility Name (If not institution, give street and number)

106 S. Conkling Street

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

n/a

Funeral
Director

5. Social Security Number

215-52-3581

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

50

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
May 24, 1947

9. Birthplace (State or Foreign Country)

Ohio

Usual Residence of Decedent

10a. State
MD

10b. County

n/a

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10a. Street and Number

106 S. Conkling Street

10f. Zip Code

21224

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

8th

College (14 or 5+)

16e. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Laminator

16b. Kind of Business/Industry

Counter Tops &
Vanities, Inc.

17. Father's Name (First, Middle, Last)

Russell R. Sloan

18. Mother's Name (First, Middle, Maiden Surname)

Mary Ennis

19e. Informant's Name/Relationship (Type, Print) wife
Glady's Sloan

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21224

106 S. Conkling St., Baltimore, Maryland

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

St. Stanislaus Cemetery

Date

12/23/97 Baltimore, Maryland

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Maria G. Zannino

22. Name and Address of Facility

Joseph N. Zannino Jr. Funeral Hm.
263 S. Conkling St. Baltimore, Maryland 2122423e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

e.

Isolated Myocardial Infarction

Due to (or as a consequence of)

Approximate
Interval Between
Onset and Death

9 months

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Dr. Purcell Sloan physician

29c. License number

D19714

29d. Date signed (Month, Day, Year)

12/24/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

MICHAEL PURCELL JR. 4940 EASTERN AVE, BALTIMORE MD 21224

31. Date filed (Month, Day, Year)

DEC 22 1997

32. Registrar's Signature

John Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

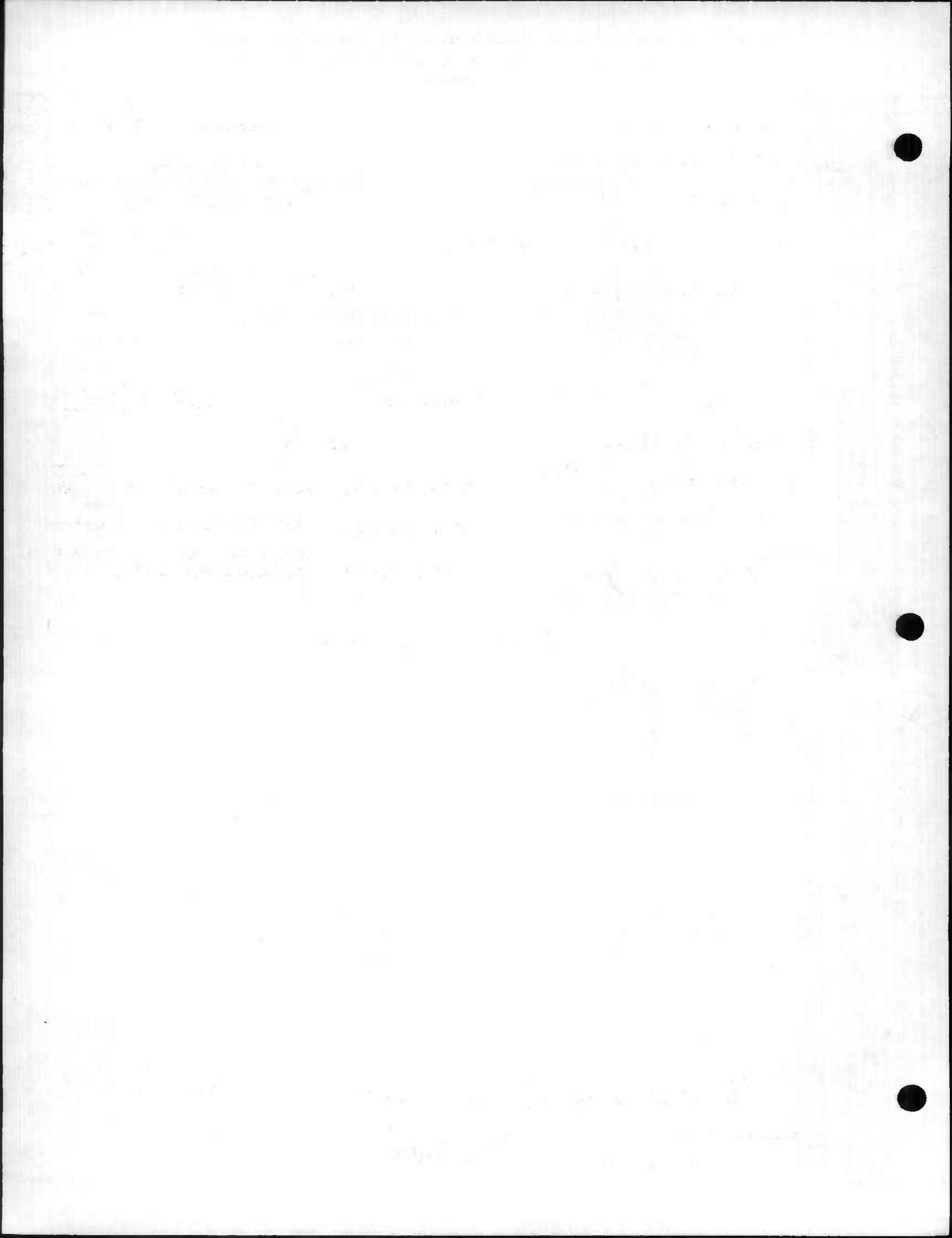
Division of Vital Records, P.O. Box 68760

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



jhm

WILLIAM ALVIN

SKEENS

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Item: 23 part II, per ME0 G-758 4/2/98 rep

Items: 23a part I, II, 27, 28a-f per ME0 G-756 2/19/98

Certificate of Death

Reg. No.

97 38585

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

William Alvin Skeens

2. Date of Death

Month Day Year
DECEMBER 19, 1997

3. Time of Death

04:45 AM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

23 NORTH POTOMAC STREET

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

5. Social Security Number

217-62-6967

6. Sex

☒ M ☐ F

7. Age (in yrs. last birthday)

43

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
April 22, 1954

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

23 North Potomac Street

10f. Zip Code

21224

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☒ Never Married ☐ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
☒ Yes ☐ No
If Yes, Give Year or Dates: 1971-7313. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12

College (14or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Laborer

16b. Kind of Business/Industry

Construction

17. Father's Name (First, Middle, Last)

Claude A. Skeens

18. Mother's Name (First, Middle, Maiden Surname)

Emma Jean Hager

19a. Informant's Name/Relationship (Type, Print)

Claude A. Skeens (Father)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7940 Eastdale Road Baltimore, Md. 21224

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Oak Lawn Cemetery

Date

12/22/1997

20c. Location - City or Town, State

Baltimore Co., Md.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Bruzdziński Funeral Home P.A.
1407 Old Eastern Avenue Essex, Md. 2122123e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.

ACUTE ETHANOL AND NARCOTIC INTOXICATION

Immediate Cause (Final
disease or condition
resulting in death)a. Cirrhosis

Due to (or as a consequence of):

b. Chronic Alcoholism

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d. Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) LastApproximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertensive Cardiovascular Disease

CIRRHOSIS OF LIVER DUE TO CHRONIC ALCOHOLISM

ATHEROSCLEROTIC CARDIOVASCULAR DISEASE

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☒ Unknown24a. Was an autopsy
performed?☒ Yes ☐ No24b. Were autopsy findings
available prior to
completion of cause
of death?☒ Yes ☐ No25. Was case referred to medical
examiner?
☒ Yes ☐ No

Hospital:

☐ Inpatient☐ ER/Outpatient☐ DOA

Other:

☐ Nursing Home☒ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending Investigation
☐ Accident ☐ Suicide
☐ Homicide ☒ Could not be determined

28a. Date of Injury

(Month, Day, Year)
found 12/19/97

28b. Time of Injury

A
found 4:30M

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

unknown

28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)

found at home

28t. Location (Street and Number or Rural Route Number,
City or Town, State) 23 N. Potomac Street,
Baltimore, Maryland29a. Certifier
(Check only one)☐ Certifying Physician☒ Medical ExaminerTo the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

OCME

29d. Date signed (Month, Day, Year)

DECEMBER 19, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

DEC 22 1997

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

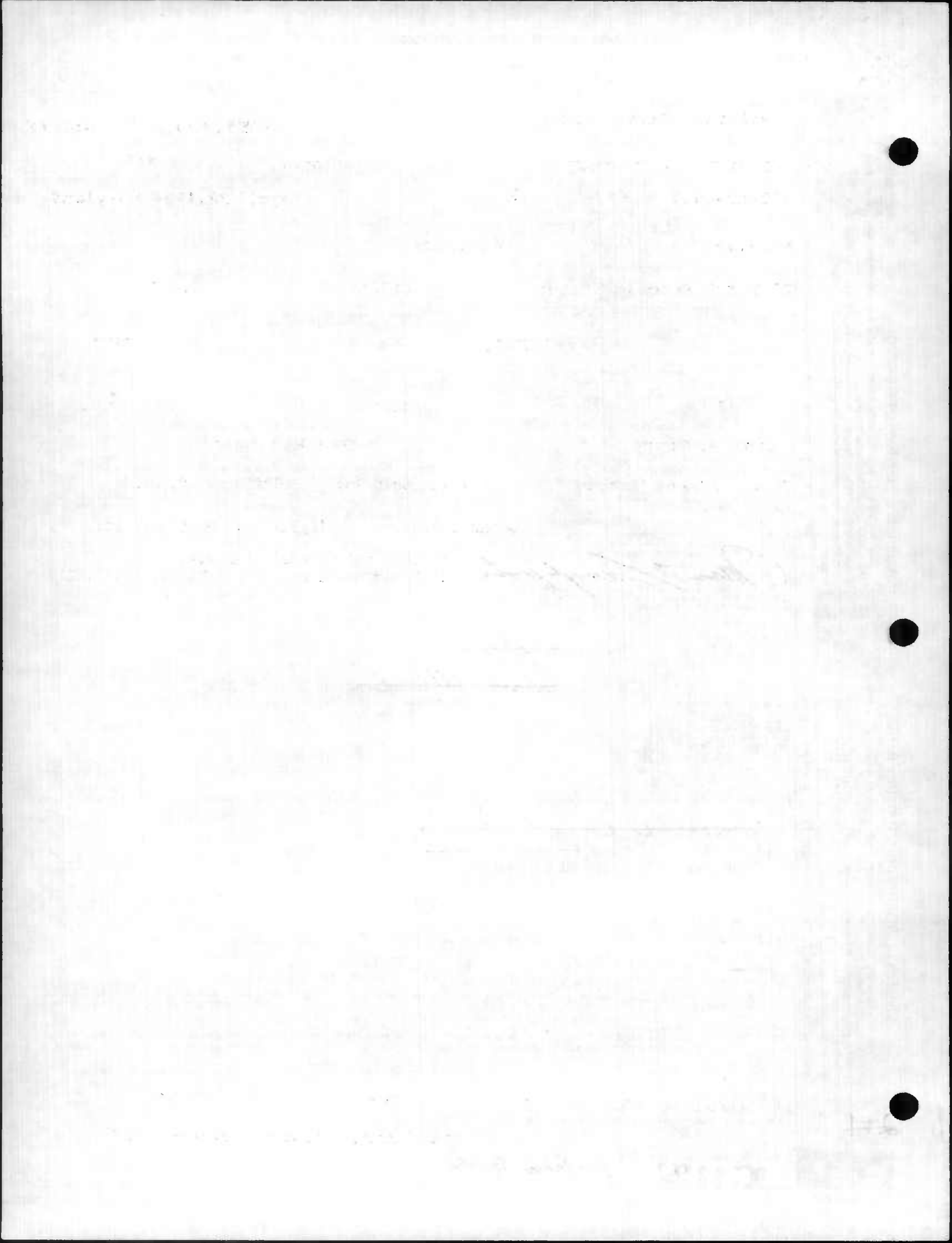
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 38586

| | | | | | | | | | | | |
|---|---|---|--|--|--|---|--|-----------------------------------|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) <i>MADLYN P SPROUL</i> | | | | | | 2. Date of Death Month <i>Dec</i> Day <i>19</i> Year <i>1997</i> | | 3. Time of Death <i>8:34</i> | | |
| | 4a. Facility Name (If not institution, give street and number) <i>HOWARD CT HOSPITAL</i> | | | | | | 4b. City, Town, or Location of Death <i>COLUMBIA</i> | | 4c. County of Death <i>HOWARD</i> | | |
| Funeral Director | 5. Social Security Number <i>206-36-8707</i> | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) <i>88</i> Yrs. | | 8. Date of Birth (Month, Day, Year) <i>2/28/1909</i> | | 9. Birthplace (State or Foreign Country) <i>SCRANTON, PA.</i> | | |
| | 10e. State <i>MD</i> | | 10b. County <i>HOWARD</i> | | 10c. City, Town or Location <i>COLUMBIA</i> | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | |
| 10e. Street and Number <i>6500 FREETOWN ROAD</i> | | 10f. Zip Code <i>21044</i> | | 10g. Citizen of What Country? <i>U.S.A.</i> | | | | | | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: <i>WHITE</i> | | | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> College (1-4or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>HOMEMAKER</i> | | 16b. Kind of Business/Industry <i>OWN HOME</i> | | | | | | | |
| 17. Father's Name (First, Middle, Last) <i>GEORGE PFEIFLE</i> | | 18. Mother's Name (First, Middle, Maiden Surname) <i>HANNAH MILLER</i> | | | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) <i>J. HARVEY SPROUL</i> | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>101 CENTRE STREET CLARKS SUMMIT, PA. 18411</i> | | | | | | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) <i>HICKORY GROVE CEMETERY</i> | | Date <i>12/23/1997</i> | | 20c. Location - City or Town, State <i>WAVERLY, PA.</i> | | | | | |
| 21. Signature of Funeral Service Licenses <i>[Signature]</i> | | 22. Name and Address of Facility <i>WITZKE FUNERAL HOMES, INC. 1630 EDMONDSON AVENUE CATONSCILLE, MD 21228</i> | | | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <i>a. RUPTURED ABDOMINAL AORTIC ANEURYSM</i> Due to (or as a consequence of): <i>b. AORTIC DEGENERATIVE DISEASE</i> Due to (or as a consequence of): <i>c. AGING PROCESS</i> Due to (or as a consequence of): <i>d.</i> | | Approximate Interval Between Onset and Death <i>6-8 HRS</i> | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>COLONIC INFARCTION 2° TO A.</i> | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | | | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | |
| 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury <i>M</i> | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier <i>[Signature]</i> | | 29c. License number <i>D18108</i> | | 29d. Date signed (Month, Day, Year) <i>DEC 19, 1997</i> | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>827 LINDEN AVE BALT. MD 21201</i> | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) <i>DEC 22 1997</i> | | 32. Registrar's Signature <i>[Signature]</i> | | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38587

| | | | | | | | | | | | | | | | | | | | | |
|--|--|---------------------------------------|---|--|--|--|---|--|---|------------------------|----------------------------------|---------------|--------------------------------------|----------------------------------|---------------|----|----------------------------------|--|----|----------------------------------|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Mary E. Somers | | | | 2. Date of Death Month December Day 20 Year 1997 | | 3. Time of Death 12:45 PM | | | | | | | | | | | | | |
| | 4a. Facility Name (If not institution, give street and number) Althea woodland Nursing center | | | | 4b. City, Town, or Location of Death Silver Spring | | 4c. County of Death Montgomery | | | | | | | | | | | | | |
| Funeral Director | 5. Social Security Number 228-40-8296 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 92 Yrs. | | 8. Date of Birth (Month, Day, Year) June 17, 1905 | | | | | | | | | | | | | |
| | 9. Birthplace (State or Foreign Country) Virginia | | 10a. State Virginia | | 10b. County ARLington | | 10c. City, Town or Location ARLington | | | | | | | | | | | | | |
| To Be Completed by Funeral Director | Usual Residence of Decedent | | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | | |
| | 10e. Street and Number 3527 So. Four mile Run Drive | | | | 10f. Zip Code 22206 | | 10g. Citizen of What Country? USA | | | | | | | | | | | | | |
| | 11. Marital Status <input type="checkbox"/> Navar Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Black | | | | | | | | | | | | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7th | | College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Home Maker | | 16b. Kind of Business/Industry own Home | | | | | | | | | | | | | |
| | 17. Father's Name (First, Middle, Last) unknown | | | | 18. Mother's Name (First, Middle, Maiden Surname) Fannie Acors | | | | | | | | | | | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Gloria Perry - Daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3527 So. Four mile Run Dr. ARL. VA. 22206 | | | | | | | | | | | | | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) mt pleasant Bapt ch cem. | | Data 12/27/97 | | 20c. Location - City or Town, State Alexandria, Va. | | | | | | | | | | | | | |
| | 21. Signature of Funeral Service Licensee Robert B Baker Jr. | | | | 22. Name and Address of Facility CHINN Funeral Service 2605 So. Shirlington Rd. arl. Va. 22206 | | | | | | | | | | | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | | | | | | | | |
| | <table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a. Colon Cancer</td> <td>Due to (or as a consequence of):</td> <td>1 year</td> </tr> <tr> <td>b. Anemia due to colon cancer</td> <td>Due to (or as a consequence of):</td> <td>1 year</td> </tr> <tr> <td>c.</td> <td>Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>d.</td> <td>Due to (or as a consequence of):</td> <td></td> </tr> </table> | | | | | | | | Immediate Cause (Final disease or condition resulting in death) | a. Colon Cancer | Due to (or as a consequence of): | 1 year | b. Anemia due to colon cancer | Due to (or as a consequence of): | 1 year | c. | Due to (or as a consequence of): | | d. | Due to (or as a consequence of): |
| Immediate Cause (Final disease or condition resulting in death) | a. Colon Cancer | Due to (or as a consequence of): | 1 year | | | | | | | | | | | | | | | | | |
| | b. Anemia due to colon cancer | Due to (or as a consequence of): | 1 year | | | | | | | | | | | | | | | | | |
| | c. | Due to (or as a consequence of): | | | | | | | | | | | | | | | | | | |
| | d. | Due to (or as a consequence of): | | | | | | | | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | | | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | | | | | | | | | | | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | |
| 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | | | | | | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | | | | | | |
| | | 28d. Describe how injury occurred | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | | | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | | | | | | | | | | |
| 29b. Signature and title of certifier Michael S. H. MD | | | | 29c. License number D21900 | | 29d. Date signed (Month, Day, Year) December 22, 1997 | | | | | | | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SMITH Ho 4610 Carroll Ave. #260 Takoma Park. Md. 20912 | | | | | | | | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 22 1997 | | | | 32. Registrar's Signature Juba Davidson-Randall | | | | | | | | | | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be completed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38588

Physician
/Medical
ExaminerFuneral
Director

| | | | | | | | |
|---|--|---|--|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last) Lettie Stambaugh | | | | 2. Date of Death Month Dec. Day 17 Year 1997 | | 3. Time of Death 5:30 PM | |
| 4a. Facility Name (If not institution, give street and number) 2109 Suburban Green Dr. | | | | 4b. City, Town, or Location of Death Timonium | | 4c. County of Death Baltimore | |
| 5. Social Security Number 220-12-5546 | | 8. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs., last birthday) 90 Yrs. | | If Under 1 Year Months Days | |
| 6. Date of Birth (Month, Day, Year) March 7, 1907 | | 9. Birthplace (State or Foreign Country) Maryland | | 10. Date of Death (Month, Day, Year) | | | |
| Usual Residence of Decedent | | | | | | | |
| 10a. State Maryland | | 10b. County Baltimore | | 10c. City, Town or Location Timonium | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10e. Street and Number 2109 Suburban Green Drive | | | | 10f. Zip Code 21093 | | 10g. Citizen of What Country? USA | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: white | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 2 College (14 or 5+) | | | | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker | | 16b. Kind of Business/Industry In Own Home | |
| 17. Father's Name (First, Middle, Last) Willis G. Merson | | | | 18. Mother's Name (First, Middle, Maiden Surname) Rosa B. | | | |
| 19a. Informant's Name/Relationship (Type, Print) Joan Finney Granddaughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2109 Suburban Green Dr. Timonium, MD 21093 | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Woodlawn Cemetery | | Date 12/19 | | 20c. Location - City or Town, State Woodlawn, MD | |
| 21. Signature of Funeral Service Licensee  | | | | 22. Name and Address of Facility Burgee-Henss Funeral Home 3631 Falls Rd Baltimore, MD 21211 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. Pneumonia Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | | | | |
| Approximate Interval Between Onset and Death 1 day | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | |
| | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. Describe how Injury occurred | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| 29b. Signature and title of certifier  | | | | 29c. License number D 23074 | | 29d. Date signed (Month, Day, Year) 12-18-97 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Richard L. Diamond, M.D. 3730 Falls Rd. Balto, Md 21211 | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 22 1997 | | | | 32. Registrar's Signature  | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be completed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **97 38589**
Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

MARTHA

SCHRUFER

2. Date of Death

18 DECEMBER 1997

3. Time of Death

12:30 AM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Saint Joseph Medical Center

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

5. Social Security Number

219-10-4492

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

95 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

9/7/02

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD

10b. County

BALTIMORE

10c. City, Town or Location

JACKSONVILLE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3613 SOUTHSIDE AVENUE

10f. Zip Code

21131

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify:

WHITE

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

7th GRADE

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

DRILL PRESS OPERATOR

16b. Kind of Business/Industry

BLACK & DECKER

17. Father's Name (First, Middle, Last)

WALTER EYRE

18. Mother's Name (First, Middle, Maiden Surname)

CATHERINE SIMMS

19a. Informant's Name/Relationship (Type, Print)

BESSIE GEISELMAN DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

16 VALLEY ROAD JACOBUS, PA 17407

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

PROVIDENCE UNITED METH. CEM.

Date

12/20/97 TOWSON, MD

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Heather N. Hays

22. Name and Address of Facility

JOHNSON FUNERAL HOME 8521 LOCH RAVEN BLVD.
TOWSON, MD 2128623a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

HYPOTHERMIA

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending

Investigation

6 ☐ Could not be

determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)

28d. Describe how Injury occurred

28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Physician2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Francis Khoo M.D.

29c. License number

D30263

29d. Date signed (Month, Day, Year)

12-18-97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FRANCIS KHOO M.D., 7620 YORK ROAD, TOWSON, MARYLAND 21204

31. Date filed (Month, Day, Year)

DEC 22 1997

32. Registrar's Signature

Julia Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760

Permit: Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be completed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 38590

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Mary Alice Townsend

2. Date of Death
Month Day Year
DECEMBER 18, 19973. Time of Death
5:47 AM

4a. Facility Name (If not institution, give street and number)

Stella Maris Hospice @ Mercy

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

NA

Funeral
Director

5. Social Security Number

227-46-9431

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

59

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
04-05-38

9. Birthplace (State or Foreign Country)

VA

Usual Residence of Decedent

10a. State

Md

10b. County

NA

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1716 East Fayette Street

10f. Zip Code

21231

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: Black

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12th Grade

College (1-4 or 5+)

NA

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

in home

17. Father's Name (First, Middle, Last)

Daniel

Whitlow

18. Mother's Name (First, Middle, Maiden Surname)

Florence

Davis

19a. Informant's Name/Relationship (Type, Print)

Clyde W. townsend

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2820 E. Chase Street Baltimore, Maryland 21213

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Garrison Forest VA Cem. 12-23-97 Owings Mills,

Date

20c. Location - City or Town, State Md.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Baltimore, Maryland 21202

WM.C. March FH 1101 E. North Avenue

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a. METASTATIC GASTRIC CANCER

Due to (or as a consequence of):

~ 1 year

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) STELLA MARIS HOSPICE @ MERCY

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)2 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D40480

29d. Date signed (Month, Day, Year)

December 18, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FERNANDO J. FERRER, MD

7672 BELAIR RD

BALTO, MD 21236

31. Date filed (Month, Day, Year)

DEC 22 1997

32. Registrar's Signature

John Davidson-Randall

State
RegistrarTOWNSEND, MARY
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural," or items 23a or 23a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 38591

Certificate of Death

Reg. No.

| | | | | | |
|---|---|---|---|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) CLARENCE THOMPSON | | 2. Date of Death Month DECEMBER Day 15 Year 1997 | | 3. Time of Death 8:32 PM |
| | 4a. Facility Name (If not institution, give street and number) Good Samaritan Hospital | | 4b. City, Town, or Location of Death Baltimore | | 4c. County of Death NA |
| Funeral Director | 5. Social Security Number 219-30-3171 | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (in yrs. last birthday) 61 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. |
| | 8. Date of Birth (Month, Day, Year) 07-03-36 | | 9. Birthplace (State or Foreign Country) MD | | |
| To Be Completed by Funeral Director | Usual Residence of Decedent | | 10a. State MD | | 10b. County NA |
| | 10c. City, Town or Location Baltimore | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | 10e. Street and Number 1508 Pentridge Road Apt. #137 | | 10f. Zip Code 21239 | | 10g. Citizen of What Country? USA |
| | 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
| | 14. Race - American Indian, Black, White, etc. Specify: Black | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7th Grade College (1-4 or 5+) NA | | |
| | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Laborer | | 16b. Kind of Business/Industry Factory Worker | | |
| | 17. Father's Name (First, Middle, Last) Herbert Peterson | | 18. Mother's Name (First, Middle, Maiden Surname) Ethel B. Thompson | | |
| | 19a. Informant's Name/Relationship (Type, Print) Ethel B. Thompson | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21239 1508 Pentridge Road Apt. #137 Baltimore, Md. | | |
| | 20e. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Voshell Mem. Gardens 12-19-97 Dundalk, Md. | | Date |
| | 21. Signature of Funeral Service Licensee Karen M. Koger | | 22. Name and Address of Facility Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue | | |
| Physician /Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | Approximate Interval Between Onset and Death |
| | Immediate Cause (Final disease or condition resulting in death) | | | | Unknown |
| | a. Pneumonia Due to (or as a consequence of): | | | | Unknown |
| | b. HIV Due to (or as a consequence of): | | | | Unknown |
| | c. Sepsis Due to (or as a consequence of): | | | | 2 days |
| | d. | | | | |
| | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | |
| | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | |
| | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28d. Describe how injury occurred | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | |
| 29b. Signature and title of certifier Ali Movssa, MD | | 29c. License number P09301 | | 29d. Date signed (Month, Day, Year) December 15, 1997 | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) ALI MOVSSA GSH 5601 LOCH RAVEN BVD BALTIMORE, MD 21239 | | | | | |
| 31. Date filed (Month, Day, Year) DEC 22 1997 | | 32. Registrar's Signature Juha Davidson-Rondale | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 38592

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

EWNICE THOMPSON

2. Date of Death

Month Day Year
DECEMBER 12 1997 15:20

3. Time of Death

Funeral
Director

4a. Facility Name (If not institution, give street and number)

R. ADAMS COWLEY SHOCK TRAUMA CENTER

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

5. Social Security Number

215-22-1742

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

93 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Apr. 3, 1904

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

4620 Schenley Road

10f. Zip Code

21210

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,
Black, White, etc.

Specify: white

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)
12

Collage (1-4or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Volunteer

16b. Kind of Business/Industry

Community Services

17. Father's Name (First, Middle, Last)

Karl Gustav Petersen

18. Mother's Name (First, Middle, Maiden Surname)

Ellen Louise Porter

19a. Informant's Name/Relationship (Type, Print)

Arthur David Thompson Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

P.O. Box 309 Bozman, Maryland 21612-0309

20a. Method of Disposition

☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of
cemetery, crematory or other place)

Loudon Park Cemetery

Date

12/18/97 Baltimore, MD

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Tracy H. Carpenter

22. Name and Address of Facility

Burgee-Henss Funeral Home
3631 Falls Road Baltimore, MD 21211

23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.

Immediate Cause (Final
disease or condition
resulting in death)

e. MULTIPLE INJURIES

Due to (or as a consequence of):

b. PELVIC FRACTURES

Due to (or as a consequence of):

c. LIVER LACERATIONS

Due to (or as a consequence of):

d. SPLENIC LACERATIONS

Approximate
Interval Between
Onset and Death

48 HRS

48 HRS

48 HRS

48 HRS

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy
performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings
available prior to
completion of cause
of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical
examiner?
1 ☒ Yes 2 ☐ No

Hospital:

1 ☒ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending
Investigation
2 ☒ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury
(Month, Day Year)

DEC 10 1997 1520 M

28b. Time of
Injury

1 ☐ Yes 2 ☒ No

28c. Injury or
Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

MOTOR VEHICLE CRASH

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)

CHARLES AT COLDSRING

28f. Location (Street and Number or Rural Route Number,
City or Town, State)

CHARLES AT COLDSRING

29a. Certifier
(Check only
one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

William C. Chin, M.D.

29c. License number

D 46147

29d. Date signed (Month, Day, Year)

DECEMBER 12 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WILLIAM CHIN, M.D. R. ADAMS COWLEY STC BALTIMORE, MD. 21201

31. Date filed (Month, Day, Year)

DEC 23 1997

32. Registrar's Signature

Judith Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

Physician
/Medical
Examiner

To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be completed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

CRAIG LEMASTER TARBERT

Items: 23a part I, 27 per ME0 G-755 1/15/98 dh

Certificate of Death

Reg. No.

97 38593

| | | | | | | | | |
|--|--|--|--|--|--|--|--|---|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Craig LeMaster Tarbert | | | | 2. Date of Death Month Day Year DEC. 16, 1997 | | 3. Time of Death 11:32 PM | |
| | 4a. Facility Name (If not institution, give street and number) FALLSTON GENERAL HOSPITAL | | | | 4b. City, Town, or Location of Death FALLSTON | | 4c. County of Death HARFORD | |
| Funeral Director | 5. Social Security Number 214-70-8050 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 39 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) 7/31/58 | 9. Birthplace (State or Foreign Country) Maryland |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State PA | | 10b. County York | | 10c. City, Town or Location Delta | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10e. Street and Number 720 Main Street | | | | 10f. Zip Code 17314 | | 10g. Citizen of What Country? USA | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify White | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Lineman | | 16b. Kind of Business/Industry Utility Company | | |
| 17. Father's Name (First, Middle, Last) James O. Tarbert | | | | 18. Mother's Name (First, Middle, Maiden Surname) Ruth LeMaster | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Pamela J. Tarbert- wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 720 Main St., Delta, PA 17314 | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Slateville Cemetery | | 20c. Location - City or Town, State 12/20/97 Delta, PA | | |
| 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility Harkins F.H. Inc., Delta, PA 17314 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | | | | | | | Approximate Interval Between Onset and Death |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred |
| 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier | | 29c. License number O.C.M.E | | 29d. Date signed (Month, Day, Year) DEC. 17, 1997 | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) M.D. Harrison P. 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 22 1997 | | 32. Registrar's Signature | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 38594

| | | | | | | | | |
|--|---|--|---|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) BABY BOY A WEININGER | | | | 2. Date of Death Month: DECEMBER Day: 20 Year: 1997 | | 3. Time of Death 7:00a | |
| | 4a. Facility Name (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL | | | | 4b. City, Town, or Location of Death BALTIMORE CITY | | 4c. County of Death N/A | |
| Funeral Director | 5. Social Security Number N/A | | 6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 0 Yrs. | | 8. Date of Birth (Month, Day, Year) Dec 20 1997 | |
| | 10a. State MD | | 10b. County Baltimore | | 10c. City, Town or Location Owings Mills | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| To Be Completed by Funeral Director | 10e. Street and Number 9321 Groffs Mill Rd | | | | 10f. Zip Code 21117 | | 10g. Citizen of What Country? USA | |
| | 11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12): 0 Collage (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) N/A | | 16b. Kind of Business/Industry N/A | | | |
| | 17. Father's Name (First, Middle, Last) David Weininger | | | | 18. Mother's Name (First, Middle, Maiden Surname) Robin Chubb | | | |
| | 19a. Informant's Name/Relationship (Type, Print) David Weininger / father | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9321 Groffs Mill Rd Owings Mills, MD | | | |
| | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Oak Lawn Cemetery | | 20c. Location - City or Town, State Baltimore, MD | | 20d. Date Dec 22 1997 | |
| | 21. Signature of Funeral Service Licensee Anthony Colt Connolly | | | | 22. Name and Address of Facility Connolly Funeral Home of Dundalk 7110 Sollers Point Rd 21222 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death, or shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. extreme prematurity b. preterm premature rupture of membranes c. twin gestation d. Due to (or as a consequence of): | | | | | | | |
| | 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| | 23c. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| | 27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicidal 4 <input type="checkbox"/> Homicidal 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28d. Describe how injury occurred | | | | | |
| | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| | 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| State Registrar | 29b. Signature and title of certifier EVA PRESSMAN | | | | 29c. License number D42614 | | 29d. Date signed (Month, Day, Year) 12/20/97 | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EVA PRESSMAN, M.D. 600 N. VEST ST. Balto. MD 21287 | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 22 1997 | | 32. Registrar's Signature John Davidson | | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38595

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Thomas Wilburne

2. Date of Death

December 18 1997

3. Time of Death

1:45 PM

4a. Facility Name (If not institution, give street and number)

FT HOWARD VAMCS

4b. City, Town, or Location of Death

Fort Howard

4c. County of Death

Md

Funeral
Director

5. Social Security Number

213 28 6263

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

72 YRS Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

MAY 18 1925

9. Birthplace (State or Foreign Country)

Md

Usual Residence of Decedent

10a. State

Md

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1212 N. Augusta Avenue

10f. Zip Code

21229

10g. Citizen of What Country?

U S A

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: 7-13-44
1-21-1947

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

7th grade

College (1-4 or 5+)

N/A

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Laborer

16b. Kind of Business/Industry

Pepsi Company

17. Father's Name (First, Middle, Last)

John Bradford

18. Mother's Name (First, Middle, Maiden Surname)

Mamie Bradford

19a. Informant's Name/Relationship (Type, Print)

Blanche Pinkney - Sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1212 N. Augusta Avenue Baltimore, Md 21229

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Garrison Forest Vet

Date

12-23-97

20c. Location - City or Town, State

Owings Mills, Md

21. Signature of Funeral Service Licensee

Gabrielle Cook

22. Name and Address of Facility

March F/H West

4300 Wabash Avenue Baltimore, Md 21215

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CANCER, LUNG

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 YEARS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

HYPERTENSION, STROKE, DEMENTIA

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home

5 ☐ Residence

6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Tan, Aurora

29c. License number

D 14958

29d. Date signed (Month, Day, Year)

December 18, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TAN, AURORA M.D. 9600 NORTH POINT ROAD FT. HOWARD, MD. 21062

31. Date filed (Month, Day, Year)

DEC 22 1997

32. Registrar's Signature

John Davidson-Randall

State
Registrar

THOMAS WILBURN

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38596

| | | | | | | | | | |
|--|--|---|--|---|--|--|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Marvin W. WILLIS | | | | 2. Date of Death Month December Day 21 Year 1997 | | 3. Time of Death 11:00 pm | | |
| | 4a. Facility Name (If not institution, give street and number) Franklin Square Hospital Center | | | | 4b. City, Town, or Location of Death Rosedale | | 4c. County of Death Baltimore | | |
| Funeral Director | 5. Social Security Number 401-01-8285 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 82 Yrs. | | 8. Date of Birth (Month, Day, Year) July 9, 1915 | | |
| | 9. Birthplace (State or Foreign Country) Virginia | | 10a. State MD | | 10b. County Baltimore | | 10c. City, Town or Location Baltimore | | |
| Usual Residence of Decedent | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number 8018 Eastdale Rd | | 10f. Zip Code 21224 | | 10g. Citizen of What Country? USA | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1945 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Welder | | 16b. Kind of Business/Industry Coast Guard | | 17. Father's Name (First, Middle, Last) Andy Willis | | 18. Mother's Name (First, Middle, Maiden Surname) Sarah Collins | |
| 19a. Informant's Name/Relationship (Type, Print) Anna Willis / wife | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8018 Eastdale Rd Baltimore, MD 21224 | | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Oak Lawn Cemetery | | 20c. Location - City or Town, State Baltimore, MD | |
| 21. Signature of Funeral Service Licensee Anthony C. Connelly | | 22. Name and Address of Facility Connelly Funeral Home of Dundalk 7110 Sollers Point Rd 21222 | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Severely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. Severe Dehydration Due to (or as a consequence of): b. Suspected Left Renal Cell Cancer Due to (or as a consequence of): c. History of Upper Gastrointestinal Bleed Due to (or as a consequence of): d. | | Approximate Interval Between Onset and Death 48 Hours 1 Year 2 Months | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | |
| 24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | |
| 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier Lij Matthew M.D. | | 29c. License number D50164 | | 29d. Date signed (Month, Day, Year) December 22, 1997 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Lij Matthew M.D. 9000 Franklin Square Drive Baltimore, Maryland 21237 | | 31. Date filed (Month, Day, Year) DEC 22 1997 | | 32. Registrar's Signature Julia Davidson-Randall | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38597

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

BABY BOY B

WEININGER

2. Date of Death

Month Day Year
DECEMBER 20 1997

3. Time of Death

7:15a

4a. Facility Name (If not institution, give street and number)
THE JOHNS HOPKINS HOSPITAL4b. City, Town, or Location of Death
BALTIMORE CITY4c. County of Death
N/AFuneral
Director

5. Social Security Number

N/A

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

0

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)
Dec 20 1997

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Owings Mills

10d. Inside City Limits

1 ☐ Yes ☒ No

10e. Street and Number

9321 Groffs Mill Rd

10f. Zip Code

21117

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

0

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

N/A

16b. Kind of Business/Industry

N/A

17. Father's Name (First, Middle, Last)

David Weininger

18. Mother's Name (First, Middle, Maiden Surname)

Robin Chubb

19a. Informant's Name/Relationship (Type, Print)

David Weininger / father

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9321 Groffs Mill Rd Owings Mills, MD

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Oak Lawn Cemetery

Data

Dec 22

1997

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

Anthony C. Connelly

22. Name and Address of Facility

Connelly Funeral Home of Dundalk

7110 Sollers Point Rd 21222

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

Due to (or as a consequence of):

extreme prematurity

b.

Due to (or as a consequence of):

preterm premature rupture of membranes

c.

Due to (or as a consequence of):

twin gestation

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

E. K. H.

29c. License number

D42614

29d. Date signed (Month, Day, Year)

12/20/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LEVA-PRESSMAN

600 N. Wolfe St BALTO. MD 21287

31. Date filed (Month, Day, Year)

DEC 22 1997

32. Registrar's Signature

Julia Gordon-Rodriguez

State
Registrar

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be completed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 38598

Item: 5, per F.H. G-755

1/20/98 reb

Certificate of Death

Reg. No.

John Wheeler
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician / Medical Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | | |
|---|--|--|--------------------------------|--|--|
| 1. Decedent's Name (First, Middle, Last) John Alexander Wheeler | | 2. Date of Death Month December Day 18 Year 1997 | | 3. Time of Death 05:24 A | |
| 4a. Facility Name (If not institution, give street and number) Greater Balto. Med Hospice | | 4b. City, Town, or Location of Death Balto. | | 4c. County of Death N. A. | |
| 5. Social Security Number 212-52-8222 | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 63 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) 2/26/34 |
| 9. Birthplace (State or Foreign Country) MD | | Usual Residence of Decedent | | | |
| 10a. State MD. | 10b. County N. A. | 10c. City, Town or Location Baltimore | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10e. Street and Number 1135 E. Northern PKWAY | | 10f. Zip Code 21239 | | 10g. Citizen of What Country? U. S. A | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | |
| 14. Race - American Indian, Black, White, etc. Specify: Black | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) | | | |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) machine operator | | 16b. Kind of Business/Industry Western Electric | | | |
| 17. Father's Name (First, Middle, Last) Shirley Wheeler | | 18. Mother's Name (First, Middle, Maiden Surname) MABEL GREEN | | | |
| 19a. Informant's Name/Relationship (Type, Print) Edith Wheeler | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1135 E. Northern PKWAY Balto MD 21239 | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) mt Zion Cem | | 20c. Location - City or Town, State Landstowne, MD | |
| 21. Signature of Funeral Service Licensee Joseph M. Locke Jr | | 22. Name and Address of Facility Locke Funeral Home 1304 N. Central Ave | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | |
| Immediate Cause (Final disease or condition resulting in death) | | e. Astrocystoma of Brain | | | Approximate Interval Between Onset and Death 9 years |
| Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | b. Due to (or as a consequence of): | | | |
| | | c. Due to (or as a consequence of): | | | |
| | | d. Due to (or as a consequence of): | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | |
| 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) Hospice | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | |
| 29b. Signature and title of certifier W.A. Riley MD | | 29c. License number D25205 | | 29d. Date signed (Month, Day, Year) December 18, 1997 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) W.A. Riley GMC 6701 N. Charles St. Balto, MD 21204 | | | | | |
| 31. Date filed (Month, Day, Year) DEC 22 1997 | | 32. Registrar's Signature John Randall | | | |

State Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 38599

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

Funeral
Director

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | | | | |
|---|--|--|--|--|--|---|--|
| 1. Decedent's Name (First, Middle, Last) KATHERINE WHEELY | | | | 2. Date of Death Month Dec Day 17 Year 1997 | | 3. Time of Death 1:00 AM | |
| 4a. Facility Name (If not institution, give street and number) STELLA MARIS HOSPICE | | | | 4b. City, Town, or Location of Death TOWSON | | 4c. County of Death BALTIMORE | |
| 5. Social Security Number 212-03-6601 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 80 Yrs. | | 8. Date of Birth (Month, Day, Year) 7/2/17 | |
| 9. Birthplace (State or Foreign Country) MARYLAND | | 10a. State MD | | 10b. County BALTIMORE | | 10c. City, Town or Location TOWSON | |
| 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number 2300 DULANEY VALLEY ROAD M-207 | | 10f. Zip Code 21204 | | 10g. Citizen of What Country? USA | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12TH GRADE | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) LIBRARIAN | | 16b. Kind of Business/Industry BALTIMORE CO. IMM. HEART OF MARY | | 17. Father's Name (First, Middle, Last) FRANK VAETH | |
| 18. Mother's Name (First, Middle, Maiden Surname) CATHERINE SCHOTT | | 19a. Informant's Name/Relationship (Type, Print) BARBARA WHEELY DAUGHTER | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 405 HOLLEN ROAD BALTIMORE, MD 21212 | | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | |
| 20b. Place of Disposition (Name of cemetery, crematory or other place) GARDENS OF FAITH | | 20c. Date 12/19/97 | | 20d. Location - City or Town, State PARKVILLE, MD | | 21. Signature of Funeral Service Licensee | |
| 22. Name and Address of Facility JOHNSON FUNERAL HOME 8521 LOCH RAVEN BLVD. TOWSON, MD 21286 | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Lymphoma disseminated Due to (or as a consequence of): | | 23b. Part II. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Lymphoma disseminated Due to (or as a consequence of): | | Approximate Interval Between Onset and Death | |
| 24a. Immediate Cause (Final disease or condition resulting in death) | | 24b. Due to (or as a consequence of): | | 24c. Due to (or as a consequence of): | | 24d. Due to (or as a consequence of): | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) HOSPICE | | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | |
| 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier | | 29c. License number 244128 | | 29d. Date signed (Month, Day, Year) 12/17/97 | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) DR. PENELOPE EDWARDS 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 | | 31. Date filed (Month, Day, Year) DEC 22 1997 | | 32. Registrar's Signature | | | |

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38600

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

GRACE E. WHEELLEY

2. Date of Death
Month Day Year

December 18, 1997 10:00 PM

3. Time of Death

Funeral
Director

4a. Facility Name (If not institution, give street and number)

FALLSTON GENERAL HOSPITAL

4b. City, Town, or Location of Death

FALLSTON

4c. County of Death

HARFORD

5. Social Security Number

280-14-8706

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

75 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth
(Month, Day, Year)

March 21, 1922

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State
MD10b. County
BALTIMORE

10c. City, Town or Location

ESSEX, MD

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

19 HALEY RD.

10f. Zip Code

21221

10g. Citizen of What Country?

U.S.A

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced12. Was Decedent Ever in U.S.
Armed Forces?1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: WHITE

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12thCollege (1-4 or 5+)
N/A16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

HOUSE WIFE

16b. Kind of Business/Industry

HOME

17. Father's Name (First, Middle, Last)

WADE WHEELLEY

18. Mother's Name (First, Middle, Maiden Surname)

FANNIE BEAVER

19a. Informant's Name/Relationship (Type, Print)

GRACE WADDELL (Niece)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

19 HALEY RD BALT, MD 21221

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

GARDENS OF FAITH Cem.

Date

12/22/97 ROSEDALE, MD.

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

H. Miller

22. Name and Address of Facility

HARTLEY MILLER FUNERAL HOME
7527 HARFORD RD, BALT, MD 2123423a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

e. UROSEPSIS

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

12-16-97

b. ILEUS

Due to (or as a consequence of):

12-18-97

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Last

c. COLITIS with CLOSTRIDIUM DIFFICILE

Due to (or as a consequence of):

12-17-97

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ATRIAL FIBRILLATION

DIABETES MELLITUS

CEREBRO VASCULAR ACCIDENT

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury at
Work?
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Chandler A. Krueger MD

29c. License number

D50040

29d. Date signed (Month, Day, Year)

12-19-1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1308 BUSINESS CENTER WAY, EDGEWOOD, MD 21040

31. Date filed (Month, Day, Year)

DEC 22 1997

32. Registrar's Signature

Julia Davidson-Randall

State
Registrar

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Certificate of Death

Reg. No.

97 38601

Physician
/Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | | |
|---|--|---|--|--|--|
| 1. Decedent's Name (First, Middle, Last) JEANETTE Marie YOST | | 2. Date of Death Month DEC. Day 10, Year 1997 | | 3. Time of Death 9:40 AM | |
| 4a. Facility Name (If not institution, give street and number) 300 LIGHT STREET APT.#1242- HYATT HOTEL | | 4b. City, Town, or Location of Death BALTIMORE | | 4c. County of Death N/A | |
| 5. Social Security Number 533-38-9665 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 57 Yrs. | |
| 8. Date of Birth (Month, Day, Year) Aug. 21, 1940 | | 9. Birthplace (State or Foreign Country) Washington | | | |
| 10a. State Washington | | 10b. County King | | 10c. City, Town or Location Seattle | |
| 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number 4703 Phinney Avenue North Apt. B | | 10f. Zip Code 98103 | |
| 10g. Citizen of What Country? U.S.A. | | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | |
| 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4 years College (1-4 or 5+) | |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Vice President/Finance | | 16b. Kind of Business/Industry Banking | | 17. Father's Name (First, Middle, Last) Jack Gerard Yost | |
| 18. Mother's Name (First, Middle, Maiden Surname) Mabel E. Johnson | | 19a. Informant's Name/Relationship (Type, Print) Mabel E. Johnson (mother) | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4703 Phinney Ave. North Apt. C Seattle, Washington 98103 | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Bayside Crematory | | 20c. Location - City or Town, State 12-19-97 Seattle, Washington | |
| 21. Signature of Funeral Service Licensee  | | 22. Name and Address of Facility Mitchell-Wiedefeld Home 6500 York Road Baltimore, Maryland 21212 | | 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE | |
| 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) HOTEL | | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | |
| 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. Certifier <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  | | 29b. Signature and title of certifier | | 29c. License number O.C.M.E. | |
| 29d. Date signed (Month, Day, Year) DEC. 12, 1997 | | 30. Name and address of person who completed cause of death (item 23a) (Type, Print) J. LARON LOCKE, MD 111 Penn Street, Baltimore, Maryland 21201 | | 31. Date filed (Month, Day, Year) DEC 22 1997 | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

George J. Thompson

Chas. L. ...
... ..
...

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **97 38602**
Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Leonardus Zegstroom, Sr.

2. Date of Death
Month Day Year

December 19, 1997

3. Time of Death
10:25pm

4a. Facility Name (If not institution, give street and number)

Doctor's Community Hospital

4b. City, Town, or Location of Death

Lanham

4c. County of Death

Prince George

Funeral
Director

5. Social Security Number

212-38-9867

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

72

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth
(Month, Day, Year)

Oct. 10, 1925

9. Birthplace (State or Foreign Country)

Netherlands

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Laurel

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3397 Sudlersville South

10f. Zip Code

20724

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

Grade 12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Carpenter

16b. Kind of Business/Industry

Construction

17. Father's Name (First, Middle, Last)

Leonardus Zegstroom

18. Mother's Name (First, Middle, Maiden Surname)

Jeantje vanPutten

19a. Informant's Name/Relationship (Type, Print)

Leonardus Zegstroom, Jr.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10719 Scaggsville Road Laurel, Md. 20723

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Union Cemetery

Date

12/22/97

20c. Location - City or Town, State

Burtonsville, Md.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Donaldson Funeral Home, P.A.

313 Talbott Avenue Laurel, Md. 20707

Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a.

Sepsis with dehydration

1 week

Due to (or as a consequence of):

b.

Extensive decubitus ulcers

Due to (or as a consequence of):

c.

Cerebrovascular accident

Due to (or as a consequence of):

d.

Cardiomyopathy with congestive heart failure

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes mellitus

Peripheral vascular disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined28a. Date of Injury
(Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D1 2863

29d. Date signed (Month, Day, Year)

12.20.97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hassan Molavi, M.D. 6005 Landover Rd. Cheverly, Md. 20785

31. Date filed (Month, Day, Year)

DEC 22 1997

32. Registrar's Signature

John Davidson-Randall

State
Registrar

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the funeral-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38603

| | | | | | | | | | | | | |
|---|---|--------------------------------|---|---|--|--|--|--|---|--|--|---|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Betty Jane Adams | | | | | | 2. Date of Death Month Day Year DECEMBER 8 1997 | | | 3. Time of Death 6:00 AM | | |
| | 4a. Facility Name (If not institution, give street and number) MEMORIAL HOSPITAL & MEDICAL CENTER | | | | | | 4b. City, Town, or Location of Death CUMBERLAND | | | 4c. County of Death ALLEGANY | | |
| Funeral Director | 5. Social Security Number 219-14-6038 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 72 Yrs. | | If Under 1 Year Months Days | | If Under 24 Hrs. Hours Min. | | 8. Date of Birth (Month, Day, Year) Feb 13, 1925 | 9. Birthplace (State or Foreign Country) MD |
| | Usual Residence of Decedent | | | | | | | | | | | |
| 10a. State MD | | 10b. County Allegany | | 10c. City, Town or Location Cumberland | | | | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 10e. Street and Number 613 Williams Street | | | | 10f. Zip Code 21502 | | | | 10g. Citizen of What Country? USA | | | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: white | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Retired Nursing Asst | | | | 16b. Kind of Business/Industry Memorial Hospital | | | | |
| 17. Father's Name (First, Middle, Last) Ralph Knippenberg | | | | | | 18. Mother's Name (First, Middle, Maiden Surname) Anna (McCarty) | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Patrick Adams-son | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1017 Penhurst Avenue Cumberland MD 21502 | | | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Sunset Memorial Park | | Data 12/10 | | 20c. Location - City or Town, State Cumberland MD | | | | |
| 21. Signature of Funeral Service Licensee  | | | | | | 22. Name and Address of Facility Scarpelli Funeral Home Cumberland MD 21502 | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. ADVANCED CARCINOMA BREAST Dua to (or as a consequence of): b. Dua to (or as a consequence of): c. Dua to (or as a consequence of): d. Dua to (or as a consequence of): Approximate Interval Between Onset and Death 5 years | | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | | | | | | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accidental <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | | | |
| 29b. Signature and title of certifier  | | | | | | 29c. License number D 23371 | | 29d. Date signed (Month, Day, Year) DEC 8, 97 | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) QAMAR ZAMAN M.D., JOHNSON HEIGHTS MEDICAL BLDG., CUMBERLAND, MD 21502 | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 8 1997 | | | | 32. Registrar's Signature  | | | | | | | | |

Baltimore, Maryland 21215-0020
Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

BETTY ADAMS 219-14-6038
Division of Vital Records, P.O. Box 68760,

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38604

Physician
/Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. Decedent's Name (First, Middle, Last) Wesley Covey Brown | | | | 2. Date of Death Month 12 Day 10 Year 97 | | 3. Time of Death 11:30am | |
| 4a. Facility Name (If not institution, give street and number) Caroline Nursing Home, Inc. | | | | 4b. City, Town, or Location of Death Denton | | 4c. County of Death Caroline | |
| 5. Social Security Number 212-16-1253 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 83 Yrs. | | 8. Date of Birth (Month, Day, Year) May 24, 1914 | |
| 9. Birthplace (State or Foreign Country) Delaware | | 10a. State Maryland | | 10b. County Caroline | | 10c. City, Town or Location Denton | |
| 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number 25549 Hignutt Road | | 10f. Zip Code 21629 | | 10g. Citizen of What Country? United States | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1942-1945 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Caucasian | |
| 15. Decedent's Education (Specify only highest grade completed) 11 HS Grad. | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Mechanic | | 16b. Kind of Business/Industry Automobile | | 17. Father's Name (First, Middle, Last) Serenious Powell Brown | |
| 18. Mother's Name (First, Middle, Maiden Surname) Sarah Elizabeth Covey | | 19a. Informant's Name/Relationship (Type, Print) Ruth S. Brown Wife | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 25549 Hignutt Road, Denton, Maryland 21629 | | 20. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | |
| 20b. Place of Disposition (Name of cemetery, crematory or other place) Concord Cemetery | | 20c. Date 12/12 | | 20d. Location - City or Town, State Denton, Maryland | | 21. Signature of Funeral Service Licensee  | |
| 22. Name and Address of Facility Moore Funeral Home, P.A. 12 South Second Street, Denton, Maryland 21629 | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. methicillin resistant staph aureus sepsis Due to (or as a consequence of): Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | Approximate Interval Between Onset and Death days | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. pneumonia cerebrovascular accident | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | 24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | |
| 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier  | |
| 29c. License number D47534 | | 29d. Date signed (Month, Day, Year) 12/10/97 | | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Wafik Zaki, M.D., PO Box 496, Denton, Maryland 21629 | | 31. Date filed (Month, Day, Year) DEC 11 '97 | |
| 32. Registrar's Signature  | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38605

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ALICE C. BROWN

2. Date of Death
Month Day Year

NOVEMBER 22 97 1:50 A.M.

3. Time of Death

4a. Facility Name (If not institution, give street and number)

SALISBURY CENTER GENESIS ELDERCARE

4b. City, Town, or Location of Death

SALISBURY

4c. County of Death

WICOMICO

Funeral
Director

5. Social Security Number

230-03-4505

6. Sex

1 ☐ M 2 ☐ F

7. Age (In yrs. last birthday)

83

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth
(Month, Day, Year)

MAY 1, 1914

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

md

10b. County

Wicomico

10c. City, Town or Location

Mardela Springs

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

11339 Tower La

10f. Zip Code

21837

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

6

College (1-4 or 5+)

m

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

MARCEL Packing Co

16b. Kind of Business/Industry

Basket factory

17. Father's Name (First, Middle, Last)

Arthur Brown

18. Mother's Name (First, Middle, Maiden Surname)

ANNIE Elizabeth Brown

19a. Informant's Name/Relationship (Type, Print)

Clementine Brown

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

NICK TOWERS La Mardela Springs Md. 21837

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Green Ch. Cemetery

Date

11/25/97

20c. Location - City or Town, State

Shapton mdc

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

Wilmington Facility

917 W. Isabella St Salisbury mdc

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Atherosclerotic cardiovascular disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

atrial fibrillation
chronic renal failure
hypertension

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined28a. Date of Injury
(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Rodney A. Wernich, M.D.

29c. License number

D15384

29d. Date signed (Month, Day, Year)

Nov. 22, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RODNEY A. WERNICH

100 POWER ST.

SALISBURY, Md. 21804

31. Date filed (Month, Day, Year)

DEC 09 1997

32. Registrar's Signature

[Signature]

State
Registrar

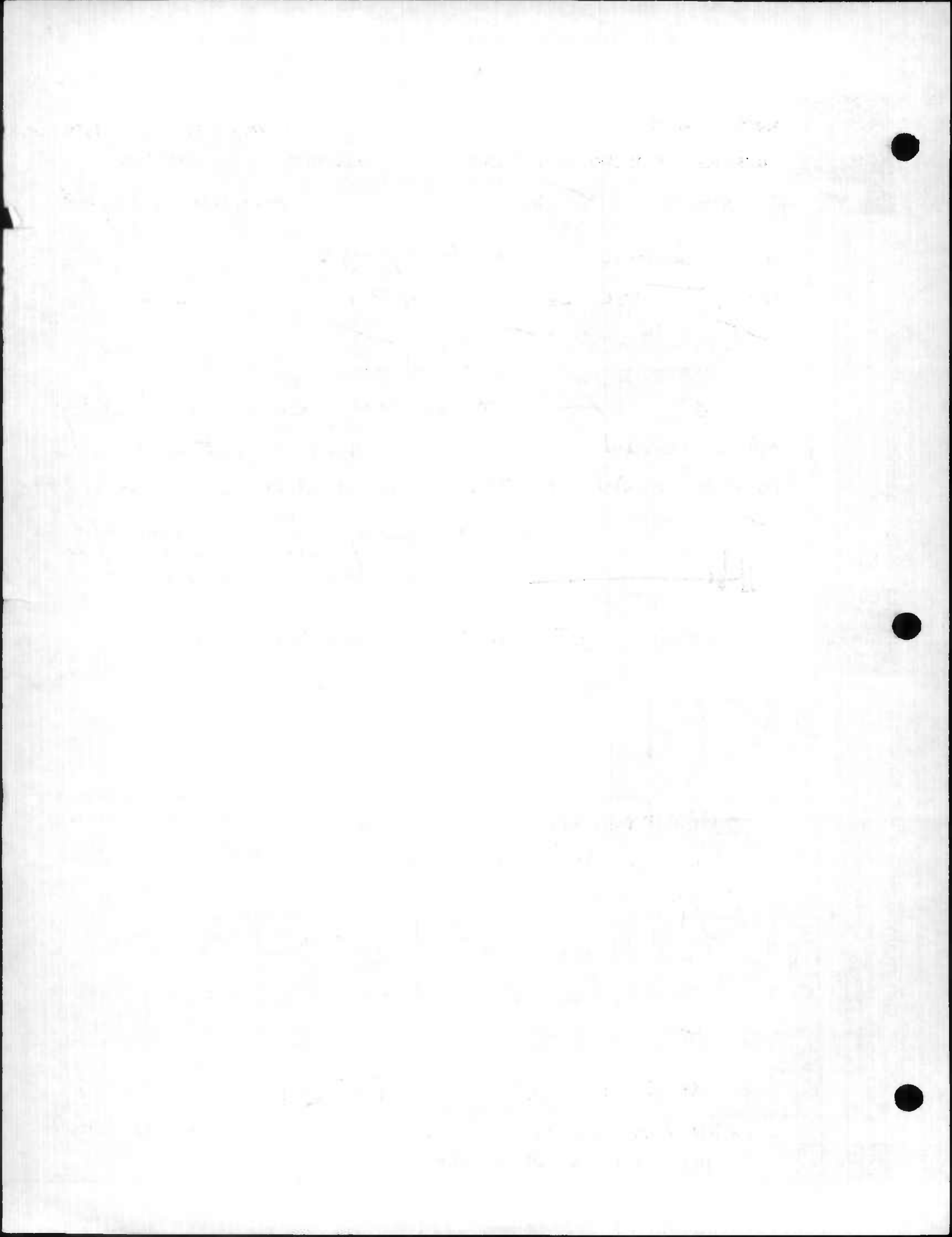
Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 38606

Physician
/Medical
Examiner

Funeral
Director

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. Decedent's Name (First, Middle, Last) BETTY BAUMGARTEN | | | | 2. Date of Death Month December Day 5 Year 1997 | | 3. Time of Death 0925 | |
| 4a. Facility Name (If not institution, give street and number) PENINSULA REGIONAL MEDICAL CENTER | | | | 4b. City, Town, or Location of Death SALISBURY | | 4c. County of Death WICOMICO | |
| 5. Social Security Number 220-26-7369 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 69 Yrs. | | 8. Date of Birth (Month, Day, Year) NOV. 12, 1928 | |
| 9. Birthplace (State or Foreign Country) PENNSYLVANIA | | 10a. State MD | | 10b. County WICOMICO | | 10c. City, Town or Location SALISBURY | |
| 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number 351 DEER'S HEAD HOSPITAL RD. | | 10f. Zip Code 21801 | | 10g. Citizen of What Country? U.S.A. | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER | | 16b. Kind of Business/Industry OWN HOME | | | |
| 17. Father's Name (First, Middle, Last) RAYMOND ROBISON | | | | 18. Mother's Name (First, Middle, Maiden Surname) MIRIAM UNKNOWN | | | |
| 19a. Informant's Name/Relationship (Type, Print) JAMES BAUMGARTEN - SON | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1626 SNOW HILL RD. STOCKTON, MD 21864 | | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) CAMBRIDGE CREMATORY | | Date 12-6-97 | | 20c. Location - City or Town, State CAMBRIDGE, MD | |
| 21. Signature of Funeral Service Licensee B. Keith Phypers CFSP | | | | 22. Name and Address of Facility BOUNDS FUNERAL HOME 705 E. MAIN ST. SALISBURY, MD 21804 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. (Long - Gehrig's Disease) ALS - amyotrophic lateral sclerosis Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | |
| 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicida <input type="checkbox"/> Homicida | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| 29b. Signature and title of certifier [Signature] | | 29c. License number 737670 | | 29d. Date signed (Month, Day, Year) 12/05/97 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. C. M. Evangelista 105 Pine Knuff Road Salisbury, MD 21801 | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 08 1997 | | | | 32. Registrar's Signature [Signature] | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

220-26-7369
Baltimore, Maryland 21215-0020
pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Betty Baumgarten
Division of Vital Records, P.O. Box 68760,

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible
State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

Reg. No.

38607

| | | | | | | | | |
|---|---|---|---|--|---|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Clyde L. Bull, Sr. | | | | 2. Date of Death Month Day Year Nov 29 1997 | | 3. Time of Death 0300 | |
| | 4a. Facility Name (If not institution, give street and number) Atlantic General Hospital | | | | 4b. City, Town, or Location of Death Berlin | | 4c. County of Death Worcester | |
| Funeral Director | 5. Social Security Number 227-38-6001 | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 63 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) April 11, 1934 | | 9. Birthplace (State or Foreign Country) VA |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State MD | | 10b. County Worcester | | 10c. City, Town or Location Berlin | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10e. Street and Number 9010 Bass Lane | | | | 10f. Zip Code 21811 | | 10g. Citizen of What Country? U.S. | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: Black | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 9th | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Laborer | | | 16b. Kind of Business/Industry Poultry | |
| 17. Father's Name (First, Middle, Last) Henry Bull | | | | 18. Mother's Name (First, Middle, Maiden Summa) Annie Boggs Bull Kellam | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Andrea Moore/daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 206 Maple Ave., P. O. Box 562, Berlin, MD 21811 | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) St. Pauls Cemetery | | Date 12/6/97 | | 20c. Location - City or Town, State Berlin, MD 21811 | | |
| 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility Lewis N. Watson Funeral Home 1618 West Rd., Salisbury, MD 21801 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>ASYSTOLE</u> Due to (or as a consequence of): b. <u>MYOCARDIAL INFARCTION</u> Due to (or as a consequence of): c. <u>CARDIOVASCULAR DISEASE</u> Due to (or as a consequence of): d. <u>HYPERTENSION</u> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | | | | | Approximate interval Between Onset and Death <u>< 5 mins</u> |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>prior Myocardial infarction 5 yrs ago</u> | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred <u>N/A</u> |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | | |
| 29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier <u>Roy Cragway M.D.</u> | | 29c. License number <u>D28466</u> | | 29d. Date signed (Month, Day, Year) <u>11/29/97</u> | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>ROY CRAGWAY JR M.D. 9733 HEATHWAY DR. BERLIN, Md. 21811</u> | | | | | | | | |
| 31. Date filed (Month, Day, Year) <u>DEC 05 1997</u> | | 32. Registrar's Signature <u>Johanna DeLeon-Rosell</u> | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Amended #17, 12/12/97, S.L., Somerset Co.

97 38608

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) SARAH Diane Bowyer | | | | 2. DATE OF DEATH MONTH 11 DAY 30 YEAR 1997 | | 3. TIME OF DEATH 6:45 A.M. | |
| 4. SOCIAL SECURITY NUMBER 213-44-0074 | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 51 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 06-15-1946 | |
| 8. BIRTHPLACE (State or Foreign Country) MD | | | | 9a. FACILITY NAME (If not Institution, give street and number) Edward McCready Memorial Hosp. | | 9b. CITY, TOWN OR LOCATION OF DEATH Crisfield | |
| 9c. COUNTY OF DEATH Somerset | | | | 10a. STATE MD | | 10b. COUNTY Somerset | |
| 10c. CITY, TOWN OR LOCATION Crisfield | | | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 10e. STREET AND NUMBER 119 South 3rd St | |
| 10f. ZIP CODE 21817 | | | | 10g. CITIZEN OF WHAT COUNTRY? U.S. | | | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Seafood | | 16b. KIND OF BUSINESS/INDUSTRY Byrd's Inc. | | | |
| 17. FATHER'S NAME (First, Middle, Last) Richard Lee Bruntington | | | | 18. MOTHER'S NAME (First, Middle, Last) Mattie Bruntington | | | |
| 19. INFORMANT'S NAME (Type Print) George Bowyer | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 119 South 3rd St. Crisfield, MD 21817 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Ebenezer Cemetery | | 20c. DATE 12-6-97 | | 20d. LOCATION — City or Town, State Marysville, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Antley E. Ward Jr. | | | | 22. NAME AND ADDRESS OF FACILITY Anthony E. Ward Funeral Home 314 Cove St. Crisfield, MD 21817 | | | |
| 23. PART I. Enter the diseases or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → myocardial infarction Approximate Interval Between Onset and Death Acute Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER M. D. Barham | | | | 29c. LICENSE NUMBER 12764 | | 29d. DATE SIGNED (Month, Day, Year) 12/14/97 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) M. D. Barham Route 413 Crisfield, Md. 21817 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) DEC - 8 1997 | | | | 32. REGISTRAR'S SIGNATURE Julia Davidson-Randall | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 5 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. The first part of the report is a general statement of the purpose and scope of the study.

2. The second part of the report is a description of the methods used in the study.

3. The third part of the report is a description of the results of the study.

4. The fourth part of the report is a discussion of the results of the study.

5. The fifth part of the report is a conclusion of the study.

6. The sixth part of the report is a list of references.

7. The seventh part of the report is a list of appendices.

8. The eighth part of the report is a list of figures.

9. The ninth part of the report is a list of tables.

10. The tenth part of the report is a list of footnotes.

11. The eleventh part of the report is a list of acknowledgments.

12. The twelfth part of the report is a list of abbreviations.

13. The thirteenth part of the report is a list of symbols.

14. The fourteenth part of the report is a list of units.

15. The fifteenth part of the report is a list of definitions.

16. The sixteenth part of the report is a list of acronyms.

17. The seventeenth part of the report is a list of initialisms.

18. The eighteenth part of the report is a list of abbreviations.

19. The nineteenth part of the report is a list of symbols.

20. The twentieth part of the report is a list of units.

21. The twenty-first part of the report is a list of definitions.

22. The twenty-second part of the report is a list of acronyms.

23. The twenty-third part of the report is a list of initialisms.

24. The twenty-fourth part of the report is a list of abbreviations.

25. The twenty-fifth part of the report is a list of symbols.

26. The twenty-sixth part of the report is a list of units.

27. The twenty-seventh part of the report is a list of definitions.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38609

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

VERONICA E. BECKNER

2. Date of Death

December 10 1997 1:25a.m.

3. Time of Death

4a. Facility Name (If not institution, give street and number)

102 Kalbaugh St.

4b. City, Town, or Location of Death

Westernport

4c. County of Death

Allegheny

Funeral
Director

5. Social Security Number

218-24-8370

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

68 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Aug 2 1929

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Md.

10b. County

Allegheny

10c. City, Town or Location

Westernport

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

102 Kalbaugh St.

10f. Zip Code

21562

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☐ No

If Yes, Give X

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

School Teacher

16b. Kind of Business/Industry

Education

17. Father's Name (First, Middle, Last)

Vernard F. Winner

18. Mother's Name (First, Middle, Maiden Surname)

Kathleen Rafferty

19a. Informant's Name/Relationship (Type, Print)

Raymond R. Beckner

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

102 Kalbaugh St. Westernport, Md. 21562

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

St. Peters Cemetery 12-13-97 Westernport, Md.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

F. W. B. B.

22. Name and Address of Facility

Boal Funeral Home
111 Church St. Westernport, Md.

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a. Glioblastoma Multiform

9 months

Due to (or as a consequence of):

b. Left side weakness

8 weeks

Due to (or as a consequence of):

c. Surgery

8 weeks

Due to (or as a consequence of):

d.

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending
investigation6 ☐ Could not be
determined

28a. Date of Injury

(Month, Day Year)

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office

building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number,

City or Town, State)

29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

John Mehana M.D.

29c. License number

D-17526

29d. Date signed (Month, Day, Year)

December, 10, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

John Mehana M.D. 902 Seton Dr. Cumberland, Md. 21502

31. Date filed (Month, Day, Year)

DEC 11 1997

32. Registrar's Signature

John Mehana M.D.

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

6
msState
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 38610

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

VIOLET RUTH BROWN

2. Date of Death
Month Day Year

DECEMBER 11 1997

3. Time of Death

4:35 AM

4a. Facility Name (If not institution, give street and number)

10908 CASH VALLEY ROAD

4b. City, Town, or Location of Death

LAVALE

4c. County of Death

ALLEGANY

Funeral
Director

5. Social Security Number

177-09-4673 A

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

83

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

AUGUST 24 1914

9. Birthplace (State or Foreign Country)

PA.

Usual Residence of Decedent

10a. State

PA.

10b. County

MERCER

10c. City, Town or Location

FARRELL

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

2015 MADISON STREET

10f. Zip Code

16121

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No

Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

WHITE

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

10

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

HOUSE KEEPER

16b. Kind of Business/Industry

HOUSE KEEPER

17. Father's Name (First, Middle, Last)

JAMES P. SULLIVAN

18. Mother's Name (First, Middle, Maiden Surname)

SARAH NUGENT

19a. Informant's Name/Relationship (Type, Print)

JAMES E. HOSFELT

SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10908 CASH VALLEY ROAD LAVALE, MARYLAND 21502

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

MOREFIELD CEMETERY DEC 15 1997

Date

20c. Location - City or Town, State

HERMITAGE, PA.

21. Signature of Funeral Service Licensee

Dale L. Merritt

22. Name and Address of Facility

MERRITT-ADAMS FUNERAL HOME

404 DECATUR STREET CUMBERLAND MARYLAND

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. LUNG CANCER

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

MONTHS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation2 ☐ Accident3 ☐ Suicide4 ☐ Homicide6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Virginia G. Magbojos, M.D.

29c. License number

D 50931

29d. Date signed (Month, Day, Year)

DECEMBER 11, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. VIRGINIA G. MAGBOJOS 912 SETON DRIVE CUMBERLAND MARYLAND 21502

31. Date filed (Month, Day, Year)

DEC 11 1997

32. Registrar's Signature

John A. ...

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the Burial-Transit form.

Thurs 11 to Sat

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38611

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

MARGARET SARAH CINTRA

2. Date of Death

Month

Day

Year

11

30

97

1608

3. Time of Death

4a. Facility Name (If not institution, give street and number)

PRMC

4b. City, Town, or Location of Death

Salisbury

4c. County of Death

Wicomico

Funeral
Director

5. Social Security Number

221-22-1416

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

62 Yrs.

8. Date of Birth

Month Day Year

9. Birthplace (State or Foreign Country)

March 11, 1935

10. Usual Residence of Decedent

10a. State

10b. County

10c. City, Town or Location

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

10f. Zip Code

10g. Citizen of What Country?

626 Liberty Street

21801

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12

College

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

16b. Kind of Business/Industry

Daily Times

Mail Room

17. Father's Name (First, Middle, Last)

Major Richardson Sr

18. Mother's Name (First, Middle, Maiden Surname)

Annie Richardson Rogers

19a. Informant's Name/Relationship (Type, Print)

Teresa Costen

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

523 Pricella St Salisbury Mde 21801

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

20c. Date

20d. Location - City or Town, State

Harmon Family Cemetery

12/1/97

Bx Mar Va

21. Signature of Funeral Service Licensee

E. D. Doherty

22. Name and Address of Facility

22a. Date

22b. Location - City or Town, State

319 Delac St

Boston Md.

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. metastatic small cell lung cancer

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

10 mo.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

J. J. Russo

29c. License number

D 20507

29d. Date signed (Month, Day, Year)

12/1/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Joseph A. Grasso 145 E. Carroll St Salisbury MD

31. Date filed (Month, Day, Year)

DEC 08 1997

32. Registrar's Signature

John Davidson-Randall

State
Registrar

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 38612

Certificate of Death

Reg. No.

| | | | | | |
|---|--|--|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Angela Therese Chambers | | 2. Date of Death Month Day Year December 4, 1997 | | 3. Time of Death 8:30 AM |
| | 4a. Facility Name (If not institution, give street and number) 1942 Durham Drive | | 4b. City, Town, or Location of Death Cumberland | | 4c. County of Death Allegany |
| Funeral Director | 5. Social Security Number 213-92-3414 | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (in yrs. last birthday) 36 Yrs. | 8. Date of Birth (Month, Day, Year) March 9, 1961 | 9. Birthplace (State or Foreign Country) MD |
| | Usual Residence of Decedent | | | | |
| To Be Completed by Funeral Director | 10a. State MD | 10b. County Allegany | 10c. City, Town or Location Cumberland | | 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |
| | 10a. Street and Number 1942 Durham Drive | | 10f. Zip Code 21502 | | 10g. Citizen of What Country? USA |
| | 11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |
| | 14. Race - American Indian, Black, White, etc. Specify: white | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 15 Yrs. Special Ed. College (1-4 or 5+) 15 Yrs. Special Ed. | | |
| | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Low Function skills | | 16b. Kind of Business/Industry Activities Center | | |
| | 17. Father's Name (First, Middle, Last) Gerald Freeman Chambers | | 18. Mother's Name (First, Middle, Maiden Surname) Maria Therese Koenig | | |
| | 19a. Informant's Name/Relationship (Type, Print) Gerald F. Chambers (father) | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1942 Durham Drive Cumberland, Md. 21502 | | |
| | 20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Cumberland Crematory 12/4/97 | | 20c. Location - City or Town, State Cumberland, MD |
| | 21. Signature of Funeral Service Licensee  | | 22. Name and Address of Facility Merritt-Adams Funeral Home 404 Decatur St. Cumberland, Md. 21502 | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Down's Syndrome with complications Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | |
| 23b. Approximate Interval Between Onset and Death 36 years | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | |
| 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | | | |
| 24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | |
| 25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | |
| 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input checked="" type="checkbox"/> Could not be determined | | | | | |
| 28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 28d. Describe how injury occurred 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | |
| 29b. Signature and title of certifier  29c. License number D 09157 29d. Date signed (Month, Day, Year) Dec 5, 1997 | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Paul Snow, M.D. 124 W. Third St. Cumberland, Md. 21502 | | | | | |
| 31. Date filed (Month, Day, Year) DEC 10 1997 32. Registrar's Signature  | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Charles Michael Cook

2. Date of Death

Month Day Year
NOVEMBER 28 1997

3. Time of Death

10:10 PM

4a. Facility Name (If not institution, give street and number)

MEMORIAL HOSPITAL & MEDICAL CENTER

4b. City, Town, or Location of Death

CUMBERLAND

4c. County of Death

ALLEGANY

5. Social Security Number

236-13-1199

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

40 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Oct. 6, 1957

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

WV

10b. County

Mineral

10c. City, Town or Location

Keyser

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

Rt. 5, Box 23

10f. Zip Code

26726

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☒ Never Married ☐ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
☐ Yes ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No -
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Manager

16b. Kind of Business/Industry

Bottling Company

17. Father's Name (First, Middle, Last)

John A. Cook

18. Mother's Name (First, Middle, Maiden Surname)

Louetta Hott

19a. Informant's Name/Relationship (Type, Print)

John A. Cook / Father

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

P.O. Box 245 Rawlings, MD 21557

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Dawson Cemetery

Date

Dec. 2
1997

20c. Location - City or Town, State

Rawlings, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Rotruck-Smith Funeral Home

85 South Main Street Keyser, WV 26726

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

e. Advanced carcinoma of colon

Due to (or as a consequence of):

Aug. 1995

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Intestinal obstruction

Due to (or as a consequence of):

3 weeks

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown24a. Was an autopsy
performed?☐ Yes ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?☐ Yes ☒ No25. Was case referred to medical
examiner?☐ Yes ☒ No

Hospital:

☒ Inpatient☐ ER/Outpatient☐ DOA

26. Place of Death (Check only one)

Other:

☐ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending
investigation
☐ Accident ☐ Could not be
determined
☐ Suicide ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury at
Work?☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

29c. License number

D 23371

29d. Date signed (Month, Day, Year)

DEC 1, 97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

QAMAR ZAMAN M.D., 625 KENT AVE. SUITE 102, CUMBERLAND, MD 21502

31. Date filed (Month, Day, Year)

DEC 08 1997

32. Registrar's Signature

John A. Cook

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transitCHARLES COOK 236-13-1199
Division of Vital Records, P.O. Box 68760,State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38614

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

THERMAN

RANDOFF

DAVIS

2. Date of Death

Month

Day

Year

DECEMBER 9, 1997

3. Time of Death

6:00 A.M.

4a. Facility Name (If not institution, give street and number)

MEMORIAL HOSPITAL

4b. City, Town, or Location of Death

CUMBERLAND

4c. County of Death

ALLEGANY

5. Social Security Number

219-03-9767

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

77

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

MAY 24 1920

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

ALLEGANY

10c. City, Town or Location

CUMBERLAND

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

726 BEDFORD STREET

10f. Zip Code

21502

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☐ Married

☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☒ Yes ☐ No

If Yes, Give Year or Dates: WW11

13. Was Decedent of Hispanic Origin? (Specify Yes or No if Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

Collega (14or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

B&O RAILROAD

16b. Kind of Business/Industry

RAILROAD

17. Father's Name (First, Middle, Last)

JOHN DAVIS

18. Mother's Name (First, Middle, Maiden Surname)

TOWANDA DAVIS MOSS

19a. Informant's Name/Relationship (Type, Print)

ROLAND K. FISHER

STEP SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

509 DILLEY STREET CUMBERLAND MARYLAND 21502

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State

☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

ROCKY GAP VETERANS CEMETERY DEC 15 1997 FLINTSTONE MD.

Date

20c. Location - City or Town, State

RFD

21. Signature of Funeral Service Licensee

Wale L. Merritt

22. Name and Address of Facility

MERRITT-ADAMS FUNERAL HOME

404 DECATUR STREET CUMBERLAND MARYLAND

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. AdenoCarcinoma of the Lung

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

3 Weeks

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic Obstructive Pulmonary Disease

23b. Did tobacco use contribute to the cause of death?

☒ Yes ☐ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital: ☒ Inpatient ☐ ER/Outpatient ☐ DOA

Other:

☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural

☐ Accident

☐ Suicida

☐ Homicida

☐ Pending investigation

☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury et Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

29c. License number

D33280

29d. Date signed (Month, Day, Year)

December 9, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. SUNIL K. GUPTA 625 KENT AVE. CUMBERLAND MARYLAND 21502

31. Date filed (Month, Day, Year)

DEC 10 1997

32. Registrar's Signature

[Signature]

State Registrar

Baltimore, Maryland 21215-0020
Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

THERMAN DAVIS 219-03-9767

Division of Vital Records, P.O. Box 68760,

Handwritten signature or initials, possibly "J. H. Smith".

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38615

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Louise A. Evans

2. Date of Death

Month
DECEMBER

Day
3

Year
1997

3. Time of Death

14:25

4a. Facility Name (If not institution, give street and number)

MEMORIAL HOSPITAL

4b. City, Town, or Location of Death

CUMBERLAND

4c. County of Death

ALLEGANY

5. Social Security Number

216-80-4251

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

83

If Under 1 Year

Months

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month, Day, Year
Dec 17, 1913

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Allegany

10c. City, Town or Location

Cumberland

10d. Inside City Limits

☒ Yes 2 ☐ No

10a. Street and Number

1510 A Oldtowne Manor Apts.

10f. Zip Code

21502

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever In U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

Collage (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

John Davis

18. Mother's Name (First, Middle, Maiden Surname)

Keziah (Barth)

19a. Informant's Name/Relationship (Type, Print)

Sandra Taylor-daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

14200 Brant Road Cresaptown MD 21502

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Sunset Memorial Park

Date

12/06

20c. Location - City or Town, State

Cumberland MD

21. Signature of Funeral Service Licensee

Nicholas J. Scarpelli

22. Name and Address of Facility

Scarpelli Funeral Home
Cumberland MD 21502

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Massive Myocardial Infarction.

Due to (or as a consequence of):

14 Minutes

b. Post-Operative Laparoscopic Cholecystectomy

Due to (or as a consequence of):

24 Hours

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Richard Snider

29c. License number

D 17246

29d. Date signed (Month, Day, Year)

Dec 18/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. RICHARD SNIDER, MEMORIAL HOSPITAL, SUITE 402, CUMBERLAND, MD

31. Date filed (Month, Day, Year)

DEC 09 1997

Registrar's Signature

John [Signature]

State
Registrar

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

LOUISE EVANS 216-80-4251

Division of Vital Records, P.O. Box 68760,

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38616

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

FRED FLURER, JR.

2. Date of Death

Month
12Day
6Year
1997

3. Time of Death

7:50 AM

4a. Facility Name (If not institution, give street and number)

SALISBURY CENTER: GENESIS ELDERCARE

4b. City, Town, or Location of Death

SALISBURY

4c. County of Death

WICOMICO

Funeral
Director

5. Social Security Number

217-03-7188

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

87 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
DEC. 3, 1910

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD

10b. County

WICOMICO

10c. City, Town or Location

SALISBURY

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

510 S. PARK DR.

10f. Zip Code

21804

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No ARMY
If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

INSURANCE AGENT

16b. Kind of Business/Industry

LIFE INSURANCE

17. Father's Name (First, Middle, Last)

FREDERICK JAMES

18. Mother's Name (First, Middle, Maiden Surname)

FLURER, SR. GLENNA SMITH

19a. Informant's Name/Relationship (Type, Print)

LOUISE S. FLURER - WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

510 S. PARK DR. SALISBURY, MD 21804

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

FIRST BAPTIST CEMETERY

Date

12-9-97

20c. Location - City or Town, State

POCOMOKE CITY, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

BOUNDS FUNERAL HOME

705. E. MAIN ST.
SALISBURY, MD 21804

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. *Emphysema*
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. *Diabetes*
Due to (or as a consequence of):c. *Coronary artery disease*
Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury et Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WILLIAM H. ROBINS, M.D. HEALTHWAY DR. SALISBURY, MD 21804

31. Date filed (Month, Day, Year)

DEC 08 1997

32. Registrar's Signature

*John Davidson Randall*State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
ExaminerDivision of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38617

| | | | | | | | | |
|---|--|---|---|--|---|---|--|---|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Linda Fooks | | | | 2. Date of Death Month November Day 27 , Year 1997 | | 3. Time of Death 10:45 PM | |
| | 4a. Facility Name (If not institution, give street and number) Salisbury Center: Genesis ElderCare | | | | 4b. City, Town, or Location of Death Salisbury, MD | | 4c. County of Death Wicomico | |
| Funeral Director | 5. Social Security Number 214-67-9767 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 41 Yrs. | If Under 1 Year Months | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) Dec 5, 1955 | 9. Birthplace (State or Foreign Country) MD |
| | Usual Residence of Decedent | | | | | | | |
| To Be Completed by Funeral Director | 10a. State MD | | 10b. County Worcester | | 10c. City, Town or Location Berlin | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | 10e. Street and Number P. O. Box 381 | | | | 10f. Zip Code 21811 | | 10g. Citizen of What Country? U.S. | |
| | 11. Marital Status <input checked="" type="checkbox"/> Navar Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Black | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Housekeeper | | 16b. Kind of Business/Industry Motel | |
| | 17. Father's Name (First, Middle, Last) Marvin Derrickson | | | | 18. Mother's Name (First, Middle, Maiden Surname) Elizabeth Fooks Land | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Jovonn Pitts | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P. O. Box 381, Berlin, MD 21811 | | | |
| | 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Salisbury Crematory | | Data 12/6/97 | | 20c. Location - City or Town, State Salisbury, MD | |
| | 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility Lewis N. Watson Funeral Home 1618 West Rd., Salisbury, MD 21801 | | | |
| | 23a. Part I. Enlarge the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Cancer Cervix - Metastatic Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Approximate Interval Between Onset and Death 7 yrs. | | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | |
| | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28d. Describe how injury occurred | | | | |
| | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | |
| 29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier | | | | 29c. License number 029349 | | 29d. Date signed (Month, Day, Year) 12/28/97 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. William Robins 1104 Healthway Dr., Salisbury MD 21804 | | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 05 1997 | | 32. Registrar's Signature | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 38618

Certificate of Death

Reg. No.

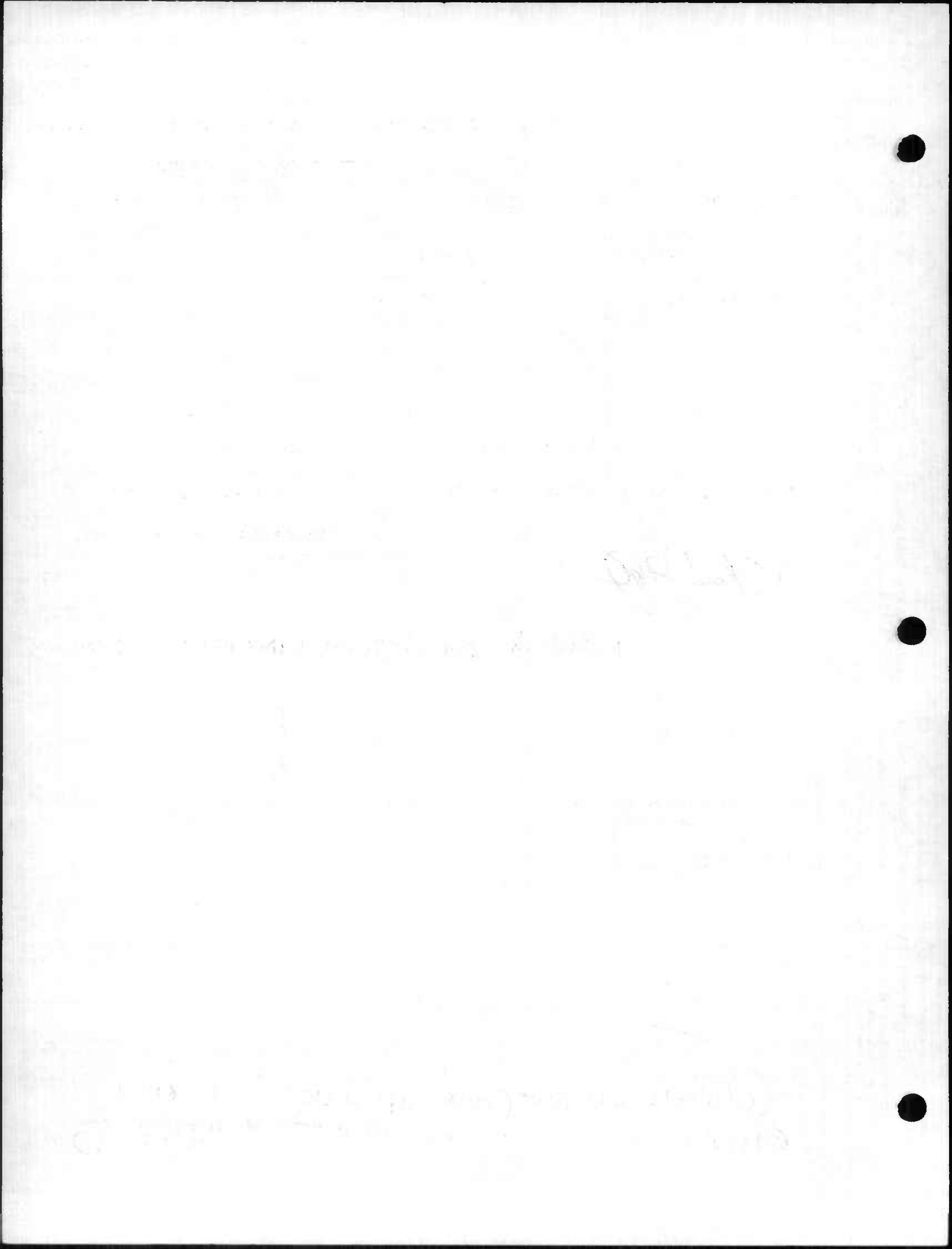
| | | | | | | | | | | | | |
|---|---|--|---|--------------------------------------|--|--|--|--|--|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) REGINA MARDEL FISHER | | | | 2. Date of Death Month Day Year DEC. 6, 1997 | | | | 3. Time of Death 7:55 PM. | | | |
| | 4e. Facility Name (If not Institution, give street and number) 19 HAHN RD. | | | | 4b. City, Town, or Location of Death WESTMINSTER | | | | 4c. County of Death CARROLL | | | |
| Funeral Director | 5. Social Security Number 214-32-2659 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 63 Yrs. | | 8. Date of Birth (Month, Day, Year) 6/12/1934 | | 9. Birthplace (State or Foreign Country) MARYLAND | | | |
| | Usual Residence of Decedent | | | | | | | | | | | |
| To Be Completed by Funeral Director | 10e. State MD. | | 10b. County CARROLL | | 10c. City, Town or Location WESTMINSTER | | | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| | 10e. Street and Number 19 HAHN RD. | | | | 10f. Zip Code 21157 | | | | 10g. Citizen of What Country? USA. | | | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOUSEWIFE | | | | 16b. Kind of Business/Industry HOMEMAKING | | | |
| | 17. Father's Name (First, Middle, Last) JAMES ROSS HAGAN | | | | 18. Mother's Name (First, Middle, Maiden Surname) GRACE AMANDA RILL | | | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print) JUNIOR R. FISHER -HUSBAND | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19 HAHN RD., WESTMINSTER, MD. 21157 | | | | | | | |
| | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) WESLEY CEMETERY | | 20c. Date 12/10/97 | | 20d. Location - City or Town, State HAMPSTEAD, MD. | | | | | |
| | 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility FLETCHER FUNERAL HOME 254 E. MAIN ST., WESTMINSTER, MD. 21157 | | | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Metastatic Bronchogenic Carcinoma Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | | | | | | | | | Approximate Interval Between Onset and Death 11 months | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 5 | | | | | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | |
| | | | | | | | | | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| | | | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 8 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | | | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | | | |
| 29b. Signature and title of certifier | | | | 29c. License number D18200 | | | | 29d. Date signed (Month, Day, Year) 12/18/97 | | | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) CHITRAKEDU NAGANNA MD 700-A POOLE RD - WESTMINSTER MD 21157 | | | | | | | | | | | | |
| State Registrar | | 31. Date filed (Month, Day, Year) DEC 09 1997 | | 32. Registrar's Signature | | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.



Amended # 19a,
Nds, 12/17/97, Allegany County

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38619

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ESTHER GARTON

2. Date of Death
Month Day Year
DECEMBER 6, 1997

3. Time of Death
0422 A.M.

4e. Facility Name (If not institution, give street and number)

SACRED HEART HOSPITAL

4b. City, Town, or Location of Death

CUMBERLAND

4c. County of Death

ALLEGANY

Funeral
Director

5. Social Security Number

213 24 6090

6. Sex
1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

78 Yrs.

8. Date of Birth (Month, Day, Year)

JAN 5, 1919

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

ALLEGANY

10c. City, Town or Location

FROSTBURG

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

10615 PRYOR LANE, SW

10f. Zip Code

FROSTBURG

10g. Citizen of What Country?

U.S.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

6

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOUSEWIFE

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

HERMAN FILSINGER

18. Mother's Name (First, Middle, Maiden Surname)

LOUISA HAUSRATH

19a. Informant's Name/Relationship (Type, Print)

Mary Ann Cummings Daughter
JAMES CUMMINGS/SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10710 TISDALE ST., NW, FROSTBURG, MD 21532

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

ECKHART CEMETERY

Date

12/8/97

20c. Location - City or Town, State

ECKHART, MD

21. Signature of Funeral Service Licensee

Maibou M. Sowers

22. Name and Address of Facility

SOWERS FUNERAL HOME, P.A.

60 W. MAIN ST., FROSTBURG, MD 21532

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. ACUTE CEREBROVASCULAR ACCIDENT

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 days

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ OOA

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

N. McCulloch

29c. License number

D 44712

29d. Date signed (Month, Day, Year)

DECEMBER 8, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

NANNETTE MCCULLOUGH MD, 921 SECON DR. Suite C Cumberland MD 21502

31. Date filed (Month, Day, Year)

DEC 09 1997

32. Registrar's Signature

John [Signature]

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1 - FOR STATE REGISTRAR | | | | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 97 38620 | | | | | | | | | |
|---|--|---|---|---|--|--|--|---|--|---|--|---|--|--------------------------------|--|--|--|
| CERTIFICATE OF DEATH | | | | REG. NO. | | | | | | | | | | | | | |
| 1. DECEASED'S NAME (First, Middle, Last) OLIVIA ALLEN HUDSON | | | | 2. DATE OF DEATH MONTH 12 DAY 2 YEAR 97 | | 3. TIME OF DEATH 7: 15 P M | | | | | | | | | | | |
| 4. SOCIAL SECURITY NUMBER 212-16-7396 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 6. AGE (In yrs. last birthday) 78 YRS. | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | | 7. DATE OF BIRTH (Month, Day, Year) 6-16-1919 | | 8. BIRTHPLACE (State or Foreign Country) PORTSMOUTH, VA. | | | | | | | |
| 9a. FACILITY NAME (If not institution, give street and number) 305 VIRGINIA AVE., | | | | 9b. CITY, TOWN OR LOCATION OF DEATH DELMAR, MD. | | | | 9c. COUNTY OF DEATH WICOMICO | | | | | | | | | |
| RESIDENCE OF DECEASED | | | | | | | | | | | | | | | | | |
| 10a. STATE MD. | | 10b. COUNTY WICOMICO | | 10c. CITY, TOWN OR LOCATION DELMAR | | | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | | | |
| 10e. STREET AND NUMBER 305 VIRGINIA AVE., | | | | 10f. ZIP CODE 21875 | | | | 10g. CITIZEN OF WHAT COUNTRY? USA | | | | | | | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEASED EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR OATHS | | 13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc. Specify: AFRO-AMERICAN | | | | | | | | | |
| 15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 11th College (1-4 or 5+) 11th | | | | 16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) DOMESTIC | | | | 16b. KIND OF BUSINESS/INDUSTRY HOUSEKEEPER | | | | | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) ROBERT ALLEN | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) PEARL COULBOURNE | | | | | | | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) JANICE SEWELL/DAUGHTER | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 629 PRISCILLA STREET; SALISBURY, MD. 21801 | | | | | | | | | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) GREEN ACRES MEMORY PARK 12-6 | | 20c. LOCATION — City or Town, State SALISBURY, MD. 21801 | | | | | | | | | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Loretta B. Jolley</i> | | | | 22. NAME AND ADDRESS OF FACILITY JOLLEY MEMORIAL CHAPEL 1213 JERSEY ROAD; SALISBURY, MD. 21801 | | | | | | | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>metastatic lung Ca</i> DUE TO (OR AS A CONSEQUENCE OF): Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | | | | Approximate Interval Between Onset and Death 30mo | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | | | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | | | | | | | | |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Joseph N. Grasso MD</i> | | 29c. LICENSE NUMBER D 20507 | | 29d. DATE SIGNED (Month, Day, Year) 12/8/97 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Joseph N. Grasso 145 E. Carroll St Salisbury MD | | | | | | | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) DEC 08 1997 | | | | 32. REGISTRAR'S SIGNATURE <i>John Driscoll-Randall</i> | | | | | | | | | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38621

| | | | | | | | | | | | |
|---|--|---|--|---|---|---------------------------------|---|--|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Edith M. Henry | | | | 2. Date of Death Month Dec Day 04 Year 1997 | | | | 3. Time of Death 0340 | | |
| | 4a. Facility Name (If not institution, give street and number) Atlantic General Hospital | | | | 4b. City, Town, or Location of Death Berlin | | | | 4c. County of Death Worcester | | |
| Funeral Director | 5. Social Security Number 213-22-4875 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 73 Yrs. | | 8. Date of Birth (Month, Day, Year) Jan 3, 1923 | | 9. Birthplace (State or Foreign Country) MD | | |
| | Usual Residence of Decedent | | | | | | | | | | |
| 10a. State MD | | 10b. County Worcester | | 10c. City, Town or Location Berlin | | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| 10e. Street and Number 10212 Trappe Rd. | | | | 10f. Zip Code 21811 | | | | 10g. Citizen of What Country? U.S. | | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: Black | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9th College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Domestic | | | | 16b. Kind of Business/Industry Private | | | |
| 17. Father's Name (First, Middle, Last) Handy Robins | | | | 18. Mother's Name (First, Middle, Maiden Surname) Nettie Fassett | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Isaac Powell/friend | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10212 Trappe Rd., Berlin, MD 21811 | | | | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) St. Pauls Cemetery | | Date 12/9/97 | | 20c. Location - City or Town, State Berlin, MD 21811 | | | |
| 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility Lewis N. Watson Funeral Home 1618 West Rd., Salisbury, MD 21801 | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. COPD Due to (or as a consequence of): b. Resp Failure with pneumonia 3-4 weeks Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | | Approximate Interval Between Onset and Death years | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | |
| | | | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| | | | | 28d. Describe how injury occurred | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | |
| | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | 29b. Signature and title of certifier | | | | 29c. License number D47676 | | | |
| | | | | 29d. Date signed (Month, Day, Year) 12/4/97 | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BSHOR TOULAMAT 9733 Healthway Drive Berlin MD 21811 | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 08 1997 | | | | 32. Registrar's Signature | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

87 38622

| | | | | | | | | | | |
|--|---|--|---|--|--|--|---|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Lillian Lorraine Harris | | | | | | 2. Date of Death Month December Day 2 Year 1997 | | 3. Time of Death 2016 | |
| | 4a. Facility Name (If not institution, give street and number) PENINSULA REGIONAL MEDICAL CENTER | | | | | | 4b. City, Town, or Location of Death SALISBURY | | 4c. County of Death WICOMICO | |
| Funeral Director | 5. Social Security Number 215-20-2436 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 73 Yrs. | | 8. Date of Birth (Month, Day, Year) June 12, 1924 | | 9. Birthplace (State or Foreign Country) MD | |
| | Usual Residence of Decedent | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State MD | | 10b. County Somerset | | 10c. City, Town or Location Deal Island | | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| | 10e. Street and Number 9565 Melvin White Rd. | | | | 10f. Zip Code 21821-1533 | | 10g. Citizen of What Country? U.S. | | | |
| | 11. Marital Status <input type="checkbox"/> Navar Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: Black | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 1 | | | | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Laborer | | | 16b. Kind of Business/Industry Seafood | | |
| | 17. Father's Name (First, Middle, Last) Roland Bivens, Sr. | | | | | | 18. Mother's Name (First, Middle, Maiden Surname) Xemina Robertson | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) Sheila Harris/daughter | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9565 Melvin White Rd., Deal Island, MD 21821-1533 | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) John Wesley UMC Cemetery | | 20c. Date 12/6/97 | | 20d. Location - City or Town, State Deal Island, MD | | | |
| | 21. Signature of Funeral Service Licensee | | | | | | 22. Name and Address of Facility Lewis N. Watson Funeral Home 1618 West Rd., Salisbury, MD 21801 | | | |
| | 23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> Immediate Cause (Final disease or condition resulting in death) e. PULMONARY EMBOLISM Due to (or as a consequence of): b. CARDIOVASCULAR FAILURE Due to (or as a consequence of): c. MYOCARDIAL INFARCTION Due to (or as a consequence of): d. MULTISYSTEM ORGAN FAILURE </div> <div style="width: 15%;"> Approximate Interval Between Onset and Death 5 DAYS 5 DAYS 5 DAYS 3 DAYS </div> </div> | | | | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how Injury occurred | |
| | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| | 29b. Signature and title of certifier MEDICAL STAFF | | | | 29c. License number D46029 | | 29d. Date signed (Month, Day, Year) DECEMBER 2 1997 | | | |
| State Registrar | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) ABDUL K. GARUBA, MD TLC, 12137 ELM STREET, PRINCESS ANN MD 21853 | | | | | | | | | |
| | 31. Date filed (Month, Day, Year) DEC 05 1997 | | | | 32. Registrar's Signature | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38623

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

EARL SILAS HOLLER

2. Date of Death

Month Day Year
DECEMBER 7, 1997

3. Time of Death

09:00 AM

4a. Facility Name (If not institution, give street and number)

SACRED HEART HOSPITAL

4b. City, Town, or Location of Death

CUMBERLAND

4c. County of Death

ALLEGANY

Funeral
Director

5. Social Security Number

173-14-0648

6. Sex

M 2 ☐ F

7. Age (In yrs. last birthday)

78

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year
JUNE 24, 1919

9. Birthplace (State or Foreign Country)

PENNSYLVANIA

Usual Residence of Decedent

10a. State
PA10b. County
BEDFORD

10c. City, Town or Location

BUFFALO MILLS

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

R. D. 1, BOX 66

10f. Zip Code

15534

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☐ No

If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: WHITE

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

TRUCK DRIVER

16b. Kind of Business/Industry

TRANSPORTATION

17. Father's Name (First, Middle, Last)

JACOB HOWARD HOLLER

18. Mother's Name (First, Middle, Maiden Surname)

ANNIE CORLEY

19a. Informant's Name/Relationship (Type, Print)

PEARL K. SHOEMAKER/ SISTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

R. D. 1, BUFFALO MILLS, PA 15534

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Data
DRY RIDGE CEMETERY DEC 10, 1997

20c. Location - City or Town, State

RD, BUFFALO MILLS, PA

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

HARVEY H. ZEIGLER FUNERAL HOME
HYNDMAN, PA 15545-0636

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head injury. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Endstage Multiple Myeloma
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 yrs

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D22181

29d. Date signed (Month, Day, Year)

DECEMBER 8 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Gary Wagner M.D. 925 Bishop Walsh Road Cumberland MD 21502

31. Date filed (Month, Day, Year)

DEC 9 1997

32. Registrar's Signature

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38624

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

M. FLORENCE (HARPER) HERSHBERGER, HORNER

2. Date of Death
Month Day Year

DECEMBER 7, 1997

3. Time of Death

9:40 P.M.

Funeral
Director

4a. Facility Name (If not institution, give street and number)

DEVLIN MANOR NURSING HOME

4b. City, Town, or Location of Death

CUMBERLAND

4c. County of Death

ALLEGANY

5. Social Security Number

234-36-2766

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

95

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth
(Month, Day, Year)

APRIL 27, 1902

9. Birthplace (State or Foreign Country)

WEST VIRGINIA

Usual Residence of Decedent

10a. State

WV

10b. County

MINERAL

10c. City, Town or Location

RIDGELEY

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

ROUTE 1, BOX 107

10f. Zip Code

26753

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

HOME

17. Father's Name (First, Middle, Last)

GEORGE W. HARPER, SR.

18. Mother's Name (First, Middle, Maiden Surname)

CHARLOTTE HUFFMAN

19a. Informant's Name/Relationship (Type, Print)

JUANITA LEESE / DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

ROUTE 1, BOX 107 - RIDGELEY, WV 26753

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

East Nimishillen Church Cemetery

Date

12/11/97

20c. Location - City or Town, State

HARTVILLE, OHIO

21. Signature of Funeral Service Licensee

Sturdy N. Upchurch

22. Name and Address of Facility

UPCHURCH FUNERAL HOME, P.A.

202 GREENE ST., CUMBERLAND, MD 21502

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Acute Myocardial Infarction

Due to (or as a consequence of):

Approximate interval Between Onset and Death

45 min

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Coronary Artery Disease

Due to (or as a consequence of):

15 yr

c. Atherosclerosis

Due to (or as a consequence of):

30 yr

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined28a. Date of Injury
(Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Sturdy N. Upchurch

29c. License number

D17565

29d. Date signed (Month, Day, Year)

Dec. 8, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ATBOLLING MD 922 N 2nd Hwy LeVelle MD 21502

31. Date filed (Month, Day, Year)

DEC 10 1997

32. Registrar's Signature

John D. ...

State
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 38625

#1 IRVIN 12/17/97
WCHD BBK

Certificate of Death

Reg. No.

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|---|--|---|--|--|---|--|---|----|--|---|--|------------------------------------|---------------|----|---|--|---------------------------------------|--|---|--|---|--|-----------------------------------|--|--|--|---|--|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Audrey Irving Irvin | | | | 2. Date of Death Month December Day 6 Year 1997 | | 3. Time of Death 0410 | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 4a. Facility Name (If not institution, give street and number) PENINSULA REGIONAL MEDICAL CENTER | | | | 4b. City, Town, or Location of Death SALISBURY | | 4c. County of Death WICOMICO | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Funeral Director | 5. Social Security Number 215-26-2649 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 97 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) Feb. 2 1900 | 9. Birthplace (State or Foreign Country) Maryland | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 10a. State Maryland | | 10b. County Wicomico | | 10c. City, Town or Location Parsonsbury | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| To Be Completed by Funeral Director | 10e. Street and Number P.O. Box 35 | | 10f. Zip Code 21849 | | 10g. Citizen of What Country? U.S.A | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever In U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Black | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 Collega (1-4or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Domestic | | 16b. Kind of Business/Industry None | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 17. Father's Name (First, Middle, Last) John Mitchell | | | | 18. Mother's Name (First, Middle, Maiden Surname) Mannie Holland | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) Arthur Parker (Son) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 35 Parsonsbury, Md. 21849 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Springhill Mem. Garden | | Date 12/12 | | 20c. Location - City or Town, State Hebron, Md. | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 21. Signature of Funeral Service Licensee Bladys B. Stewart | | | | 22. Name and Address of Facility Stewart Funeral Home 821 West Rd. Salisbury, Md. 21801 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a.</td> <td>CARDIAC ARREST</td> <td rowspan="4">Approximate Interval Between Onset and Death 1 hour</td> </tr> <tr> <td>b.</td> <td>ACUTE MYOCARDIAL INFARCTION</td> <td>1 hour</td> </tr> <tr> <td>c.</td> <td></td> <td></td> </tr> <tr> <td>d.</td> <td></td> <td></td> </tr> </table> | | | | | | | | Immediate Cause (Final disease or condition resulting in death) | a. | CARDIAC ARREST | Approximate Interval Between Onset and Death 1 hour | b. | ACUTE MYOCARDIAL INFARCTION | 1 hour | c. | | | d. | | | | | | | | | | | | | | | | |
| Immediate Cause (Final disease or condition resulting in death) | a. | CARDIAC ARREST | Approximate Interval Between Onset and Death 1 hour | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | b. | ACUTE MYOCARDIAL INFARCTION | | 1 hour | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | c. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | d. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <table border="1"> <tr> <td colspan="4">Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes Mellitus</td> <td colspan="4">23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown</td> </tr> <tr> <td colspan="4"></td> <td colspan="4">24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</td> </tr> <tr> <td colspan="4"></td> <td colspan="4">24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> </table> | | | | | | | | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes Mellitus | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes Mellitus | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <table border="1"> <tr> <td colspan="2">25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</td> <td colspan="6">26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)</td> </tr> <tr> <td colspan="2">27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined</td> <td colspan="2">28a. Date of Injury (Month, Day Year)</td> <td colspan="2">28b. Time of Injury M</td> <td colspan="2">28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</td> <td colspan="2">28d. Describe how Injury occurred</td> </tr> <tr> <td colspan="2"></td> <td colspan="4">28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)</td> <td colspan="3">28f. Location (Street and Number or Rural Route Number, City or Town, State)</td> </tr> </table> | | | | | | | | 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how Injury occurred | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how Injury occurred | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <table border="1"> <tr> <td colspan="8">29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.</td> </tr> <tr> <td colspan="4">29b. Signature and title of certifier [Signature]</td> <td colspan="2">29c. License number D36576</td> <td colspan="2">29d. Date signed (Month, Day, Year) 12/6/97</td> </tr> </table> | | | | | | | | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | 29b. Signature and title of certifier [Signature] | | | | 29c. License number D36576 | | 29d. Date signed (Month, Day, Year) 12/6/97 | | | | | | | | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 29b. Signature and title of certifier [Signature] | | | | 29c. License number D36576 | | 29d. Date signed (Month, Day, Year) 12/6/97 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Ronald Trautitz 560 Riverside Drive, Apt 204, Salisbury, Md. 21801 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <table border="1"> <tr> <td colspan="4">31. Date filed (Month, Day, Year) DEC 09 1997</td> <td colspan="4">32. Registrar's Signature [Signature]</td> </tr> </table> | | | | | | | | 31. Date filed (Month, Day, Year) DEC 09 1997 | | | | 32. Registrar's Signature [Signature] | | | | | | | | | | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 09 1997 | | | | 32. Registrar's Signature [Signature] | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

Audrey Irvin SS# 215-26-2649

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

perm. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

8

97-7038-039

B.K.S

CLYDE I. JOHNSON

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38626

| | | | | | |
|--|--|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Clyde Johnson | | 2. Date of Death Month Day Year DEC. 6, 1997 | | 3. Time of Death 0400 AM |
| | 4e. Facility Name (If not institution, give street and number) U.S.#13 & ROUTE#675 | | 4b. City, Town, or Location of Death PRINCESS ANNE | | 4c. County of Death SOMERSET |
| Funeral Director | 5. Social Security Number 220-84-7384 | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 32 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. |
| | 8. Date of Birth (Month, Day, Year) Feb. 27 1965 | | 9. Birthplace (State or Foreign Country) Maryland | | |
| To Be Completed by Funeral Director | 10a. State Maryland | | 10b. County Wicomico | | 10c. City, Town or Location Salisbury |
| | 10e. Street and Number 28184 Rockawalkin Ridge Road | | 10f. Zip Code 21801 | | 10g. Citizen of What Country? U.S.A |
| | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Laborer | | 14. Race - American Indian, Black, White, etc. Specify: Black |
| | 17. Father's Name (First, Middle, Last) Clyde Snowden | | 18. Mother's Name (First, Middle, Maiden Surname) Alona Johnson | | |
| | 19a. Informant's Name/Relationship (Type, Print) Alona Bloodsworth (Mother) | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 28184 Rockawalkin Ridge Rd. Salisbury, 21801 | | |
| | 20e. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Springhill Mem. Garden | | 20c. Location - City or Town, State Hebron, Md. |
| | 21. Signature of Funeral Service Licensee Gladys B. Stewart | | 22. Name and Address of Facility Stewart Funeral Home 821 West Rd. Salisbury, Md. 21801 | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | |
| | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | |
| Physician /Medical Examiner | Immediate Cause (Final disease or condition resulting in death) a. Multiple Injuries Due to (or as a consequence of): | | | | |
| | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): | | | | |
| | c. Due to (or as a consequence of): | | | | |
| | d. Due to (or as a consequence of): | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | |
| | 24e. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | |
| | 24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | |
| | 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | |
| | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | |
| | 27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) 12-6-97 | | 28b. Time of Injury 0351 M |
| 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred Automobile accident | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) US #13 and Rt. 675 Somerset County, Maryland | | | |
| 29b. Signature and title of certifier Gladys B. Stewart, MD | | 29c. License number O.C.M.E | | 29d. Date signed (Month, Day, Year) DEC. 6, 1997 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stephen S. Radentz 111 Penn Street, Baltimore, Maryland 21201 | | | | | |
| 31. Date filed (Month, Day, Year) DEC 09 1997 | | 32. Registrar's Signature Gladys B. Stewart | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

X

X

X

X

X

X

Trout & S. uphelt.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38627

187-14-5698
GEORGE JACOB
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | | | | |
|---|--|---|--|---|--------------------------------|---|--|
| 1. Decedent's Name (First, Middle, Last) GEORGE JACOB | | | | 2. Date of Death Month December Day 6 Year 1997 | | 3. Time of Death 2210 | |
| 4a. Facility Name (If not institution, give street and number) PENINSULA REGIONAL MEDICAL CENTER | | | | 4b. City, Town, or Location of Death SALISBURY | | 4c. County of Death WICOMICO | |
| 5. Social Security Number 187-14-5698 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (in yrs. last birthday) 74 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) 04/27/1923 | |
| 9. Birthplace (State or Foreign Country) Pennsylvania | | | | | | | |
| Usual Residence of Decedent | | | | | | | |
| 10a. State Maryland | | 10b. County Somerset | | 10c. City, Town or Location Princess Anne | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10e. Street and Number 12797 East Ridge Road | | | | 10f. Zip Code 21853 | | 10g. Citizen of What Country? U.S. | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9 College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Millwright | | 16b. Kind of Business/Industry Metal | |
| 17. Father's Name (First, Middle, Last) John Jacob | | | | 18. Mother's Name (First, Middle, Maiden Sumama) Anna Jacob | | | |
| 19a. Informant's Name/Relationship (Type, Print) Irene Laird Jacob/Wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12797 East Ridge Road, Princess Anne, Md. 21853 | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Beechwood Cemetery | | Date 12/10/97 | | 20c. Location - City or Town, State Princess Anne, Md. | |
| 21. Signature of Funeral Service Licensee <i>[Signature]</i> M00295 | | | | 22. Name and Address of Facility Hinman Funeral Home 11673 Somerset Avenue, Princess Anne, Md. 21853 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Cerebral Vascular Accident Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. Describe how injury occurred | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| 29b. Signature and title of certifier <i>[Signature]</i> | | | | 29c. License number 034760 | | 29d. Date signed (Month, Day, Year) 12/8/97 | |
| 30. Name and address of person who completed cause of death (item 23a) (Type, Print) TERRELL NIEZANO, M.D. 560 RIVERSIDE DR. B101 SALISBURY, MD 21801 | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 10 1997 | | | | 32. Registrar's Signature <i>[Signature]</i> | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38628

Physician
/Medical
Examiner

Funeral
Director

| | | | | | | | |
|---|-------------------------|---|---|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last) NORMA JANE MASSEY | | | | 2. Date of Death Month Day Year DECEMBER 3, 1997 | | 3. Time of Death 12:30 AM | |
| 4a. Facility Name (If not institution, give street and number) 36288 REGINAULT STREET | | | | 4b. City, Town, or Location of Death WILLARDS | | 4c. County of Death WICOMICO | |
| 5. Social Security Number 214-28-1805 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 66 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) AUG. 27, 1931 | 9. Birthplace (State or Foreign Country) MARYLAND |
| Usual Residence of Decedent | | | | | | | |
| 10a. State MARYLAND | 10b. County WICOMICO | 10c. City, Town or Location WILLARDS | | | 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 10e. Street and Number 36288 REGINAULT STREET | | | 10f. Zip Code 21874 | | 10g. Citizen of What Country? USA | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4or 5+) 10 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) SEAMSTRESS | | | 16b. Kind of Business/Industry CLOTHING | | |
| 17. Father's Name (First, Middle, Last) RUFUS T. LITTLETON | | | | 18. Mother's Name (First, Middle, Maiden Surname) MAUDE BAKER | | | |
| 19a. Informant's Name/Relationship (Type, Print) INGA J. ALMOND-HOGUE/DAUGHTER | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 28065 NANTICOKE ROAD, SALISBURY, MARYLAND 21801 | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) NEW HOPE CEMETERY | | Date 12/5/97 | 20c. Location - City or Town, State WILLARDS, MARYLAND | | |
| 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility HASTINGS FUNERAL HOME, SELBYVILLE, DELAWARE 19975 | | | |

To Be Completed by Funeral Director

| | | | |
|---|--|--|--|
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>metastatic Colon Cancer</u> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | Approximate Interval Between Onset and Death | |
|---|--|--|--|

| | | | |
|--|--|---|--|
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | |
| | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |

| | | | | | | | |
|---|--|---|--|--|--|--|--|
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 28. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | |

| | |
|--|--|
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | |
|--|--|

| | | | | | |
|---|--|--------------------------------|--|--|--|
| 29b. Signature and title of certifier | | 29c. License number D 20507 | | 29d. Date signed (Month, Day, Year) 12/3/97 | |
|---|--|--------------------------------|--|--|--|

| | |
|---|--|
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Joseph W. GRASSO 145 E. CARROLL ST SALISBURY MD | |
|---|--|

| | | | |
|--|--|-------------------------------|--|
| 31. Date filed (Month, Day, Year) DEC 03 1997 | | 32. Registrar's Signature | |
|--|--|-------------------------------|--|

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38629

| | | | | | |
|---|---|---|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) EVERETTE CALVIN | | 2. Date of Death Month DECEMBER Day 2 Year 1997 | | 3. Time of Death 1839 |
| | 4a. Facility Name (If not institution, give street and number) PENINSULA REGIONAL MEDICAL CENTER | | 4b. City, Town, or Location of Death SALISBURY | | 4c. County of Death WICOMICO |
| Funeral Director | 5. Social Security Number 214-12-6749 | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 75 Yrs. | If Under 1 Year Months 7 Days 1 | 8. Date of Birth (Month, Day, Year) 7/1/22 |
| | 9. Birthplace (State or Foreign Country) Delaware | | Usual Residence of Decedent | | |
| To Be Completed by Funeral Director | 10a. State Maryland | 10b. County Worcester | 10c. City, Town or Location Ocean City | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| | 10a. Street and Number 126 11 Torquay Road | | 10f. Zip Code 21842 | | 10g. Citizen of What Country? USA |
| | 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WW II | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+) - | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Service Man | | 16b. Kind of Business/Industry Poultry |
| | 17. Father's Name (First, Middle, Last) E. Hunter Matthews | | 18. Mother's Name (First, Middle, Maiden Surname) Lillian M. Joines | | |
| | 19a. Informant's Name/Relationship (Type, Print) Norma T. Matthews/Wife | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 126 11 Torquay Rd., Ocean City, MD 21842 | | |
| | 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Salisbury Crematory | | 20c. Location - City or Town, State Salisbury, MD |
| | 21. Signature of Funeral Service Licensee <i>[Signature]</i> | | 22. Name and Address of Facility Holloway Funeral Home 501 Snow Hill Rd., Salisbury, MD 21804 | | |
| | 23a. Pert. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | |
| | <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>a. Multi Organ System Failure, as below Due to (or as a consequence of):</p> <p>b. Cardiac Arrest Due to (or as a consequence of):</p> <p>c. Coronary Artery Disease Due to (or as a consequence of):</p> <p>d. </p> <p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</p> | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | |
| <p>Ischemic (Myocardial) Bowel Comatose state</p> <p>Acute Renal Failure, ARN COPD</p> <p>Bacteremia (Septic)</p> <p>Coronary Artery Disease</p> | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Piece of Death (Check only one) Hospitel: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | |
| 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | |
| 29b. Signature and title of certifier <i>[Signature]</i> | | 29c. License number 044069 | | 29d. Date signed (Month, Day, Year) 12.2.97 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J CINDOROUT 106 MURKIN ST #107 SALISBURY MD 21804 | | | | | |
| 31. Date filed (Month, Day, Year) DEC 05 1997 | | 32. Registrar's Signature <i>[Signature]</i> | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 38630

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ANNABELLE MARGUERITE

MANN

2. Date of Death

Month

Day

Year

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1997

2230

3. Time of Death

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4a. Facility Name (If not institution, give street and number)

PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death

SALISBURY

4c. County of Death

WICOMICO

5. Social Security Number

319-20-5482

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

76

Yrs.

8. Date of Birth

(Month, Day, Year)

5/11/21

9. Birthplace (State or Foreign Country)

Illinois

Usual Residence of Decedent

10a. State

Maryland

10b. County

Wicomico

10c. City, Town or Location

Salisbury

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

704 Burning Tree Circle

10f. Zip Code

21801

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☐ Married☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

8

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

Domestic

17. Father's Name (First, Middle, Last)

Raymond Edward Hall

18. Mother's Name (First, Middle, Maiden Surname)

Hannah Elizabeth Jacobs

19a. Informant's Name/Relationship (Type, Print)

Robert E. & Joanne Buck/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

704 Burning Tree Circle, Salisbury, MD 21801

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Grove Hill Cemetery

Date

12/6/97

20c. Location - City or Town, State

Morrison, Illinois

21. Signature of Funeral Service Licensee

David H. Thompson

22. Name and Address of Facility

Holloway Funeral Home

501 Snow Hill Rd., Salisbury, MD 21804

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Massive Stroke, complicated

Due to (or as a consequence of):

b. Chronic Atrial Fibrillation

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

3 1/2 weeks

Years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Polycythemia Vera

Coagulopathy

Myocardial Infarction

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☒ Inpatient☐ ER/Outpatient☐ DOA

Other:

☐ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Accident☐ Suicide☐ Homicide☐ Pending investigation☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

David H. Thompson

29c. License number

P44069

29d. Date signed (Month, Day, Year)

12-2-97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

J. Curran MD 106 Millers St #104

Salisbury MD 21801

31. Date filed (Month, Day, Year)

DEC 05 1997

32. Registrar's Signature

John Anderson-Randall

State Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38631

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

MARGARET WILSON MOSES

2. Date of Death

Month

Day

Year

3. Time of Death

11:15 P.M.

4a. Facility Name (If not institution, give street and number)

Egle Nursing Home

4b. City, Town, or Location of Death

Lonaconing

4c. County of Death

Allegany

Funeral
Director

5. Social Security Number

214-07-2255

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

83

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

May 2, 1914

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Allegany

10c. City, Town or Location

Lonaconing

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

15916 St. Marys Church Terrace

10f. Zip Code

21539

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married

3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever In U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

1

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Clerk

16b. Kind of Business/Industry

Grocery

17. Father's Name (First, Middle, Last)

Hugh Moses

18. Mother's Name (First, Middle, Maiden Summa)

Bella Wilson

19a. Informant's Name/Relationship (Type, Print)

John T. Shockey-Adm.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

15906 Rockville St., Lonaconing, Md. 21539

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Smithsburg Crematory Dec. 6, 1997

Date

20c. Location - City or Town, State

Smithsburg, Md.

21. Signature of Funeral Service Licensee

John E. Mike

22. Name and Address of Facility

Eichhorn-McKenzie Funeral Home

Lonaconing, Md. 21539

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Myocardial Ischemia

Due to (or as a consequence of):

7 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Congestive Heart Failure

Due to (or as a consequence of):

1 year

c. Generalized Atherosclerosis

Due to (or as a consequence of):

2 years

d.

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Profound Depression

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural

2 ☐ Accident

3 ☐ Suicide

4 ☐ Homicide

5 ☐ Pending Investigation

6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

John E. Mike

29c. License number

D07004

29d. Date signed (Month, Day, Year)

12/6/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

L.R. MIKES, JR., M.D. 57 JACKSON ST. LONA CONING MD. 21539

31. Date filed (Month, Day, Year)

DEC 09 1997

32. Registrar's Signature

John E. Mike

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38632

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Agnes Elizabeth Minnick

2. Date of Death

Month Day Year
DECEMBER 5, 1997

3. Time of Death

2110

4a. Facility Name (If not institution, give street and number)

Sacred Heart Hospital

4b. City, Town, or Location of Death

Cumberland

4c. County of Death

Allegany

5. Social Security Number

220-38-0496

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

82

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

12-Mar-15

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10e. State

Maryland

10b. County

Allegany

10c. City, Town or Location

Frostburg

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

12507 Carlos Road, S. W.

10f. Zip Code

21532-

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
8College (1-4 or 5+)
016a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Homemaker

17. Father's Name (First, Middle, Last)

Jessie Pfaff

18. Mother's Name (First, Middle, Maiden Surname)

Emma Caton

19a. Informant's Name/Relationship (Type, Print)

James Minnick Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12507 Carlos Road, S.W. Frostburg Maryland 21532-

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Johnson Cemetery

Date

08-Dec-97

20c. Location - City or Town, State

Frostburg, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a.

Congestive heart Failure

6 weeks

Due to (or as a consequence of):

b.

acute anterior wall Myocardial Infarction

6 weeks

Due to (or as a consequence of):

c.

Coronary atherosclerosis

40 years

Due to (or as a consequence of):

d.

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

acute Renal Failure Pneumonia

Diabetes mellitus Hypertension

Dementia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

29c. License number

D14464

29d. Date signed (Month, Day, Year)

DECEMBER 6, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

S. L. Sandhir, M.D., 48 Tarn Terrace, Frostburg, Maryland 21532

31. Date filed (Month, Day, Year)

DEC 09 1997

32. Registrar's Signature

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

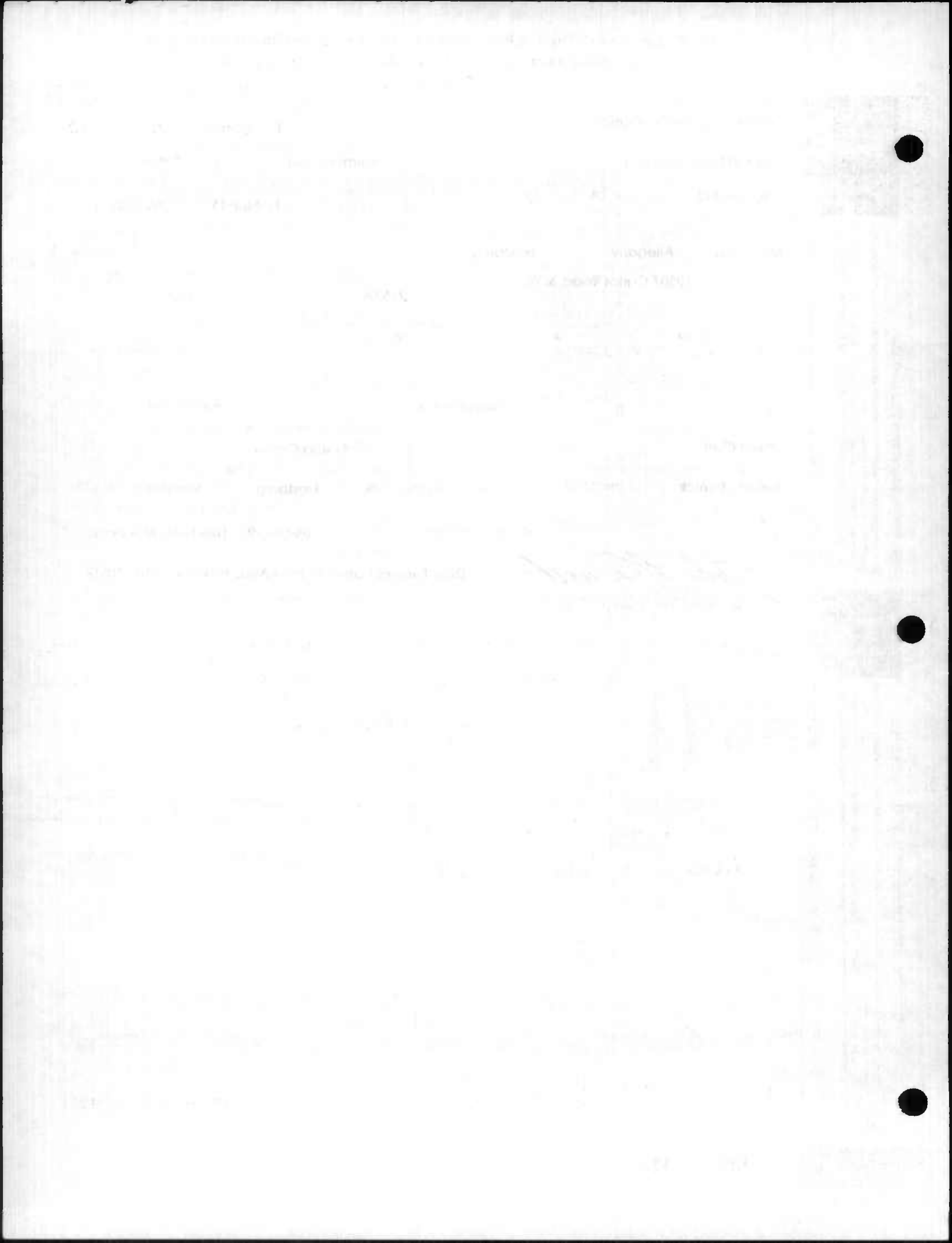
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38633

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ANNIE PEARL MILES

2. Date of Death

Month Day Year
DEC. 4, 1997

3. Time of Death

8:30 PM.

4a. Facility Name (If not institution, give street and number)

WESTMINSTER NURSING HOME

4b. City, Town, or Location of Death

WESTMINSTER

4c. County of Death

CARROLL

Funeral
Director

5. Social Security Number

419-26-2818

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

89 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
DEC. 10, 1907

9. Birthplace (State or Foreign Country)

ALABAMA

Usual Residence of Decedent

10a. State

MD.

10b. County

CARROLL

10c. City, Town or Location

FINKSBURG

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

3206 PATAPSCO RD.

10f. Zip Code

21048

10g. Citizen of What Country?

USA.

11. Marital Status

☐ Never Married ☐ Married
☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
☐ Yes ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: WHITE

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

6

College (1-4or 5+)

16. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

TEXTILE WORKER

16b. Kind of Business/Industry

MANUFACTURING

17. Father's Name (First, Middle, Last)

CLAUDE

MORROW

18. Mother's Name (First, Middle, Maiden Surname)

MINNIE

BUTLER

19a. Informant's Name/Relationship (Type, Print)

BETTY ADAMS - DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3206 PATAPSCO RD., FINKSBURG, MD. 21048

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

RESTHAVEN CEMETERY 12/7/97

Date

20c. Location - City or Town, State

LANETT, ALABAMA

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

FLETCHER FUNERAL HOME

254 E. MAIN ST., WESTMINSTER, MD. 21157

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)a. *Atherosclerotic Coronary Vessel Disease*

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

10 yr

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown24a. Was an autopsy
performed?☐ Yes ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?☐ Yes ☒ No25. Was case referred to medical
examiner?
☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient☐ ER/Outpatient☐ DOA

Other:

☒ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending
Investigation
☐ Accident ☐ Could not be
determined
☐ Suicide ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of
Injury28c. Injury at
Work?☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29e. Certifier
(Check only
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Robert L. Morrow, MD

29c. License number

032882

29d. Date signed (Month, Day, Year)

12/5/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Robert L. Morrow, 114 Business Center Drive, Reisterstown, MD 21135

31. Date filed (Month, Day, Year)

DEC 09 1997

32. Registrar's Signature

John Andrew Randall

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38634

| | | | | | | | | |
|--|--|--|--|---|--|---------------------------------|--|---|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) LOUISA JANE ROYSTER | | | | 2. Date of Death Month December Day 3 Year 1997 | | 3. Time of Death 1745 | |
| | 4a. Facility Name (If not institution, give street and number) PENINSULA REGIONAL MEDICAL CENTER | | | | 4b. City, Town, or Location of Death SALISBURY | | 4c. County of Death WICOMICO | |
| Funeral Director | 5. Social Security Number 179-38-9113 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 49 Yrs. | If Under 1 Year Months | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) DEC.17, 1947 | 9. Birthplace (State or Foreign Country) PENNSYLVANIA |
| | Usual Residence of Decedent | | | | 10e. State MD | | 10b. County WICOMICO | |
| To Be Completed by Funeral Director | 10c. City, Town or Location SALISBURY | | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number 1703 LOWER MILLSTONE LANE | |
| | 10f. Zip Code 21801 | | | | 10g. Citizen of What Country? USA | | 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | |
| | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: U.S.A. | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7 College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) PHYSICAL THERAPIST | | 16b. Kind of Business/Industry COLLEGE | |
| | 17. Father's Name (First, Middle, Last) DR. HENRY P. ROYSTER | | | | 18. Mother's Name (First, Middle, Maiden Surname) ETHEL FISHER | | | |
| | 19a. Informant's Name/Relationship (Type, Print) ETHEL F. ROYSTER | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 23 SPRINGMOOR DR., RALEIGH, N. C. 27615 | | | |
| | 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) CAMBRIDGE CREMATORY | | 20c. Location - City or Town, State 12/4/97 CAMBRIDGE MD. | |
| | 21. Signature of Funeral Service Licensee <i>Gerald E. Brunch</i> | | | | 22. Name and Address of Facility BOUNDS FUNERAL HOME, SALISBURY, MD. 21804 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. LUNG CANCER Due to (or as a consequence of): Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | | | Approximate Interval Between Onset and Death 3 yrs. | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | |
| 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 28d. Describe how injury occurred | | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. Signature and title of certifier <i>Robert B. Allen</i> | | | | |
| 29c. License number D29168 | | | | 29d. Date signed (Month, Day, Year) 12/3/97 | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ROBERT B. ALLEN, 5600 Riverside Dr. Salisbury Md. | | | | 31. Date filed (Month, Day, Year) DEC 04 1997 | | | | |
| 32. Registrar's Signature <i>John A. Harrison</i> | | | | 33. Registrar's Title Registrar | | | | |

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "Natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38635

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

JOSEPH

W.

READING

2. Date of Death

December 3 1997

3. Time of Death
2015

4a. Facility Name (If not institution, give street and number)

PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death

SALISBURY

4c. County of Death

WICOMICO

Funeral
Director

5. Social Security Number

215-36-2466

6. Sex

M ☒ F

7. Age (In yrs. last birthday)

80

8. Date of Birth (Month, Day, Year)

05/12/1917

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Somerset

10c. City, Town or Location

Princess Anne

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

28734 Polks Road

10f. Zip Code

21853

10g. Citizen of What Country?

U.S.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

11

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Farmer

16b. Kind of Business/Industry

Agriculture

17. Father's Name (First, Middle, Last)

Joseph Omar Reading

18. Mother's Name (First, Middle, Maiden Surname)

Erma Webster

19a. Informant's Name/Relationship (Type, Print)

Betty Ellis Reading/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

28734 Polks Road, Princess Anne, Md. 21853

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Allen U.M. Cemetery

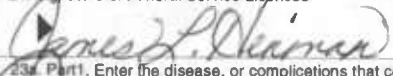
Date

12/06/97

20c. Location - City or Town, State

Allen, Maryland

21. Signature of Funeral Service Licensee



M00295

22. Name and Address of Facility

Hinman Funeral Home

11673 Somerset Ave., Princess Anne, Md. 21853

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

ASCVD

a. Due to (or as a consequence of):

2044

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

CHF

2044

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic Lymphedema

DVT

COPD

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

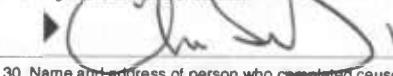
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

H50497

29d. Date signed (Month, Day, Year)

12/4/97

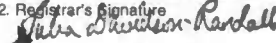
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Christopher Snyder, M.D. 108 Pine Bluff Rd Salisbury, MD

31. Date filed (Month, Day, Year)

DEC - 5 1997

32. Registrar's Signature

State
RegistrarBaltimore, Maryland 21215-0020
Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

CMK

MILTON J. ROBERTSON

Item: 8 Per Informat Film G-755 1-22-98RC

Items:23a part I,27 per MEO G-755 1/16/98 dh

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)

MILTON J. ROBERTSON

2. Date of Death

Month Day Year

DECEMBER 14, 1997

3. Time of Death

1310PM

4a. Facility Name (If not institution, give street and number)

MALCOM GROVE HOSPITAL

4b. City, Town, or Location of Death

CAMP SPRINGS

4c. County of Death

PRINCE GEORGES

5. Social Security Number

229-26-1895

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

67 Yrs.

8. Date of Birth (Month, Day, Year)

August 22, 1929

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Virginia

10b. County

Fairfax

10c. City, Town or Location

Vienna

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2149 Chain Bridge Road

10f. Zip Code

22182

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Navar Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12) College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Chief of Police

16b. Kind of Business/Industry

Front Royal, Va. Police Department

17. Father's Name (First, Middle, Last)

Joseph William Robertson

18. Mother's Name (First, Middle, Maiden Surname)

Rosie Belle Carter

19a. Informant's Name/Relationship (Type, Print)

Betty J. Robertson/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2149 Chain Bridge Rd., Vienna, Va. 22182

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

National Memorial Park

Date

12/19/97

20c. Location - City or Town, State

Falls Church, Va.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

MONEY & KING VIENNA FUNERAL HOME, INC. 171 W. Maple Ave., Vienna, Va. 22180

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE

Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

DECEMBER 15, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

David R Fowler 111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

DEC 23 1997

32. Registrar's Signature

Julia Davidson-Rendall

Physician /Medical Examiner

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

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DEC 2 1981

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

87 38637

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Floris David Raines

2. Date of Death

Dec 3 1997

3. Time of Death

4:00PM

4a. Facility Name (If not Institution, give street and number)

609 Woodlawn Terrace

4b. City, Town, or Location of Death

Cumberland

4c. County of Death

Allegany

Funeral
Director

5. Social Security Number

235-54-8022

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

67 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Jan. 17, 1930

9. Birthplace (State or Foreign Country)

West Virginia

Usual Residence of Decedent

10a. State

MD

10b. County

Allegany

10c. City, Town or Location

Cumberland

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

609 Woodlawn Terrace

10f. Zip Code

21502

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever In U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Truck Driver

16b. Kind of Business/Industry

Trucking Industry

17. Father's Name (First, Middle, Last)

Floris R. Raines

18. Mother's Name (First, Middle, Maiden Summa)

Mamie Belle Fuller

19a. Informant's Name/Relationship (Type, Print)

Arvel H. Raines Brother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

P. O. Box 389, Ft. Ashby, WV 26719

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Indian Mound Cemetery

Date

Dec. 8 1997

20c. Location - City or Town, State

Romney, WV

21. Signature of Funeral Service Licensee

Mark Shaffer

22. Name and Address of Facility

Shaffer Funeral Home, Inc.
230 East Main St., Romney, WV 26757

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Gastro intestinal bleeding

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

3 months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dty med ex

29c. License number

D 09157

29d. Date signed (Month, Day, Year)

Dec 3 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Paul Snow, M.D. 124 w 3rd st Cumb Md 21502

31. Date filed (Month, Day, Year)

DEC 08 1997

32. Registrar's Signature

John D. ...

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

people. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38638

| | | | | | | | | | | |
|---|--|---------------------------------------|---|---|--|---|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Melva L. Reinhart | | | | 2. Date of Death Month DECEMBER Day 4 Year 1997 | | | | 3. Time of Death 11:35 PM | |
| | 4a. Facility Name (If not institution, give street and number) Sacred Heart Hospital | | | | 4b. City, Town, or Location of Death Cumberland | | | | 4c. County of Death Allegany | |
| Funeral Director | 5. Social Security Number 214-07-3341 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 89 Yrs. | | 8. Date of Birth Month Jan Day 7 Year 1908 | | 9. Birthplace (State or Foreign Country) MD | |
| | Usual Residence of Decedent | | | | | | | | | |
| To Be Completed by Funeral Director | 10e. State MD | | 10b. County Allegany | | 10c. City, Town or Location Cumberland | | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| | 10e. Street and Number 738 Fayette Street | | | | 10f. Zip Code 21502 | | 10g. Citizen of What Country? USA | | | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: white | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Former Employee | | | 16b. Kind of Business/Industry Telephone Company | | |
| | 17. Father's Name (First, Middle, Last) Lawrence Meister | | | | 18. Mother's Name (First, Middle, Maiden Surname) Elsie (Zembower) | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Robert Reinhart-son | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12418 Stoney Brook Lane LaVale MD 21502 | | | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) SS Peter Paul Cemetery | | Data 12/08 | | 20c. Location - City or Town, State Cumberland MD | | | |
| | 21. Signature of Funeral Service Licensee <i>Nicholas Scarpelli</i> | | | | 22. Name and Address of Facility Scarpelli Funeral Home Cumberland MD 21502 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>Multi infarct Dementia</i> Due to (or as a consequence of): b. <i>Arterio Sclerotic Heart Disease</i> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Approximate Interval Between Onset and Death <i>5 yrs</i> <i>15 yrs</i> | | | | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Diabetes Mellitus</i> | | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicidal <input type="checkbox"/> Homicidal <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | |
| 29b. Signature and title of certifier <i>Wayne C Spiggle</i> | | | | 29c. License number D11443 | | 29d. Date signed (Month, Day, Year) DECEMBER 9, 1997 | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Wayne C. Spiggle M.D. 912 Seton Drive Cumberland MD 21502 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 09 1997 | | | | 32. Registrar's Signature <i>Jabin...</i> | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38639

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

MARY E. REBAR

2. Date of Death

Month Day Year
Dec. 7 1997

3. Time of Death

4:45p.m.

4a. Facility Name (If not institution, give street and number)

Moran Manor Nursing Home

4b. City, Town, or Location of Death

Westernport

4c. County of Death

Allegany

5. Social Security Number

235-54-7976

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

83 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

9. Birthplace (State or Foreign Country)

June 30 1914 West Virginia

Usual Residence of Decedent

10a. State

Md.

10b. County

Garrett

10c. City, Town or Location

Bloomington

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street end Number

68 Knight St.

10f. Zip Code

21523

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

Unknown

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Home

17. Father's Name (First, Middle, Last)

Thomas Flynn

18. Mother's Name (First, Middle, Maiden Surname)

Dora Davis

19a. Informant's Name/Relationship (Type, Print)

Frederick Rebar

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code)

68 Knight St. Bloomington, Md. 21523

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Bloomington Cem 12-11-97

Date

20c. Location - City or Town, State

Bloomington, Md.

21. Signature of Funeral Service Licensee

F. Wayno B. ml

22. Name and Address of Facility

Boal Funeral Home
111 Church St. Westernport, Md.23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

e. Intralable Congestive Heart Failure

2 Hours

Due to (or as a consequence of):

b. Ischemic Heart Disease

5 Years

Due to (or as a consequence of):

c. CORONARY ARTERY DISEASE

10 Years

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
2 ☐ Accident investigation
3 ☐ Suicide 6 ☐ Could not be
4 ☐ Homicide determined28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury28c. Injury at
Work?
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

S. Chang

29c. License number

D 25638

29d. Date signed (Month, Day, Year)

December 8, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

SATURNINA CHANG Rt 36 Frootburg Plaza Frootburg Maryland 21522

31. Date filed (Month, Day, Year)

DEC 11 1997

32. Registrar's Signature

John H. H. H.

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

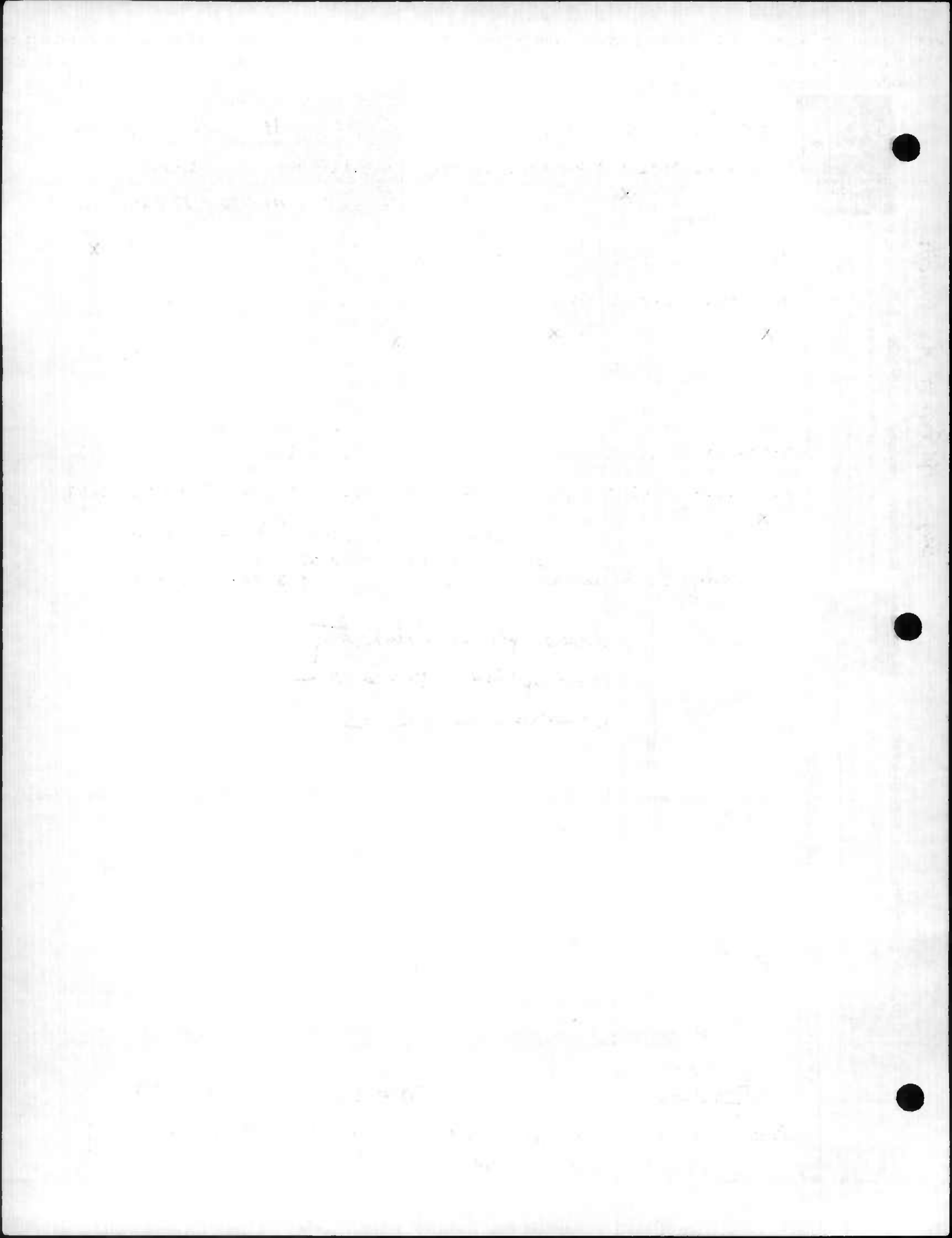
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38640

| | | | | | | | | | |
|--|--|--|---|--|--|--|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Ka'Shawn Alonzo Smith | | | | 2. Date of Death Month 11 Day 30 Year 97 | | 3. Time of Death 1830 | | |
| | 4e. Facility Name (If not institution, give street and number) Peninsula Regional Medical Center | | | | 4b. City, Town, or Location of Death Salisbury | | 4c. County of Death Wicomico | | |
| Funeral Director | 5. Social Security Number 900-10-8736 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) Yrs. 4 | | 8. Date of Birth (Month, Day, Year) NOV. 30 1997 | | |
| | 9. Birthplace (State or Foreign Country) Maryland | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State Maryland | | 10b. County Wicomico | | 10c. City, Town or Location Salisbury | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | 10e. Street and Number 1107 Apt. E Parson Road | | | | 10f. Zip Code 21801 | | 10g. Citizen of What Country? U.S.A | | |
| | 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever In U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Black | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/> | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | | 16b. Kind of Business/Industry | | | | |
| Physician /Medical Examiner | 17. Father's Name (First, Middle, Last) Clarence Alonzo Smith | | | | 18. Mother's Name (First, Middle, Maiden Surname) Kim Waller | | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Kim Waller (Mother) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1107 Apt. E Parson Rd. Salisbury, Md. 21801 | | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Springhill Mem. Garden | | 20c. Location - City or Town, State Hebron, Md. | | 20d. Date 12/6 | | |
| | 21. Signature of Funeral Service Licensee Gladys B. Stewart | | 22. Name and Address of Facility Stewart Funeral Home 821 West Rd. Salisbury, Md. 21801 | | | | | | |
| Physician /Medical Examiner | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Sudden Prematurity Due to (or as a consequence of): b. abruptio placenta Due to (or as a consequence of): c. chorioamnionitis Due to (or as a consequence of): d. | | | | | | | Approximate Interval Between Onset and Death | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | |
| | | | | | | | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | |
| | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| | | | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | |
| | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | |
| To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate. | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| | 29b. Signature and title of certifier Ba Q | | | | 29c. License number D45324 | | 29d. Date signed (Month, Day, Year) 11-30-97 | | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Isaac Ben-Or 314 W Carroll Street Salisbury MD 21801 | | | | | | | | |
| | 31. Date filed (Month, Day, Year) DEC 03 1997 | | | | 32. Registrar's Signature John A. Anderson-Randall | | | | |



97 38641

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) MARY LEE Collins Stevenson | | | | 2. DATE OF DEATH MONTH DAY YEAR November 30, 1997 | | 3. TIME OF DEATH 12:30 PM | |
| 4. SOCIAL SECURITY NUMBER 220-09-1318 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 88 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 01-16-1909 | |
| 9a. FACILITY NAME (If not institution, give street and number) PENINSULA REGIONAL MEDICAL CENTER | | | | 9b. CITY, TOWN OR LOCATION OF DEATH SALISBURY | | 9c. COUNTY OF DEATH WICOMICO | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE MD | | 10b. COUNTY Somerset | | 10c. CITY, TOWN OR LOCATION Princess Anne | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER P.O. Box 403 | | | | 10f. ZIP CODE 21853 | | 10g. CITIZEN OF WHAT COUNTRY? U.S. | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 4th College (13-16 or 17+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) laborer | | 16b. KIND OF BUSINESS/INDUSTRY Seafood | | | |
| 17. FATHER'S NAME (First, Middle, Last) John Collins | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Hester Adams | | | |
| 19a. INFORMANT'S NAME (Type/Print) Arnold Ballard | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 403 Princess Anne, MD 21853 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 6 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) John Wesley Cemetery 12/6/97 | | 20c. LOCATION — City or Town, State Princess Anne, MD | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Antly E. Ward Jr. | | | | 22. NAME AND ADDRESS OF FACILITY Anthony E. Ward Funeral Home 30639 Hampden Ave Princess Anne, MD 21853 | | | |
| 23. PART I. Enter the disease(s) or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Chronic Obstructive Pulmonary Disease, 5 yrs End Stage Approximate Interval Between Onset and Death Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Essential Hypertension Hypercholesterolemia | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Gregorio M. Bellosso M.D. | | 29c. LICENSE NUMBER D 29505 | | 29d. DATE SIGNED (Month, Day, Year) 12-1-97 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) GREGORIO M. BELLOSO M.D. 5302 CHINABERRY DR., SALISBURY, MD 21801 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) DEC - 8 1997 | | | | 32. REGISTRAR'S SIGNATURE John Andrew Randall | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Pages 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38642

| | | | | | | | | | | | | | | | | | | | | |
|--|--|---|--|---|---|--|---|---|----|------------------------------------|-------------|----|---------------------|--------------|----|-------------|--------------|----|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Augusta Lauradeen Sutton | | | | 2. Date of Death Month December Day 4 Year 1997 | | 3. Time of Death 5:41 PM | | | | | | | | | | | | | |
| | 4a. Facility Name (If not institution, give street and number) Sacred Heart Hospital | | | | 4b. City, Town, or Location of Death Cumberland | | 4c. County of Death Allegany | | | | | | | | | | | | | |
| Funeral Director | 5. Social Security Number 193-24-6736 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (in yrs. last birthday) 73 Yrs. | | 8. Date of Birth (Month, Day, Year) 10-Jan-24 | | | | | | | | | | | | | |
| | 9. Birthplace (State or Foreign Country) Pennsylvania | | 10a. State Maryland | | 10b. County Allegany | | 10c. City, Town or Location Frostburg | | | | | | | | | | | | | |
| Usual Residence of Decedent | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number 10224 New Hope Road, N.W. | | 10f. Zip Code 21532- | | | | | | | | | | | | | | |
| 10g. Citizen of What Country? U.S.A. | | 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | | | | | | | | | | | | |
| 14. Race - American Indian, Black, White, etc. Specify White | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+) 0 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker | | 16b. Kind of Business/Industry Homemaker | | | | | | | | | | | | | | |
| 17. Father's Name (First, Middle, Last) Robert Walker | | | | 18. Mother's Name (First, Middle, Maiden Surname) Goldeen Dishong | | | | | | | | | | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Claude Sutton Husband | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10224 New Hope Road Frostburg Maryland 21532- | | | | | | | | | | | | | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Restlawn Memorial Gardens | | 20c. Location - City or Town, State 08-Dec-97 LaVale, Maryland | | | | | | | | | | | | | | |
| 21. Signature of Funeral Service Licensee  | | | | 22. Name and Address of Facility Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 | | | | | | | | | | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | | | | | | | | | |
| <table border="1"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last </td> <td>a.</td> <td>Acute myocardial infarction</td> <td>1 hr</td> </tr> <tr> <td>b.</td> <td>Hypertension</td> <td>5 yrs</td> </tr> <tr> <td>c.</td> <td>COPD</td> <td>5 yrs</td> </tr> <tr> <td>d.</td> <td></td> <td></td> </tr> </table> | | | | | | | | Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. | Acute myocardial infarction | 1 hr | b. | Hypertension | 5 yrs | c. | COPD | 5 yrs | d. | | |
| Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. | Acute myocardial infarction | 1 hr | | | | | | | | | | | | | | | | | |
| | b. | Hypertension | 5 yrs | | | | | | | | | | | | | | | | | |
| | c. | COPD | 5 yrs | | | | | | | | | | | | | | | | | |
| | d. | | | | | | | | | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | | | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | | | | | | | | | | | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | | | | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | |
| 28d. Describe how injury occurred | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | | | | | | | | | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | | | | | | | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Certifying Physician: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | | | | | | | | | | |
| 29b. Signature and title of certifier  | | 29c. License number D 13166 | | 29d. Date signed (Month, Day, Year) 12-04-97 | | | | | | | | | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) ANGEL H. ROQUE M.D. 48 Tann Terrace Frostburg | | | | | | | | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 09 1997 | | 32. Registrar's Signature  | | | | | | | | | | | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

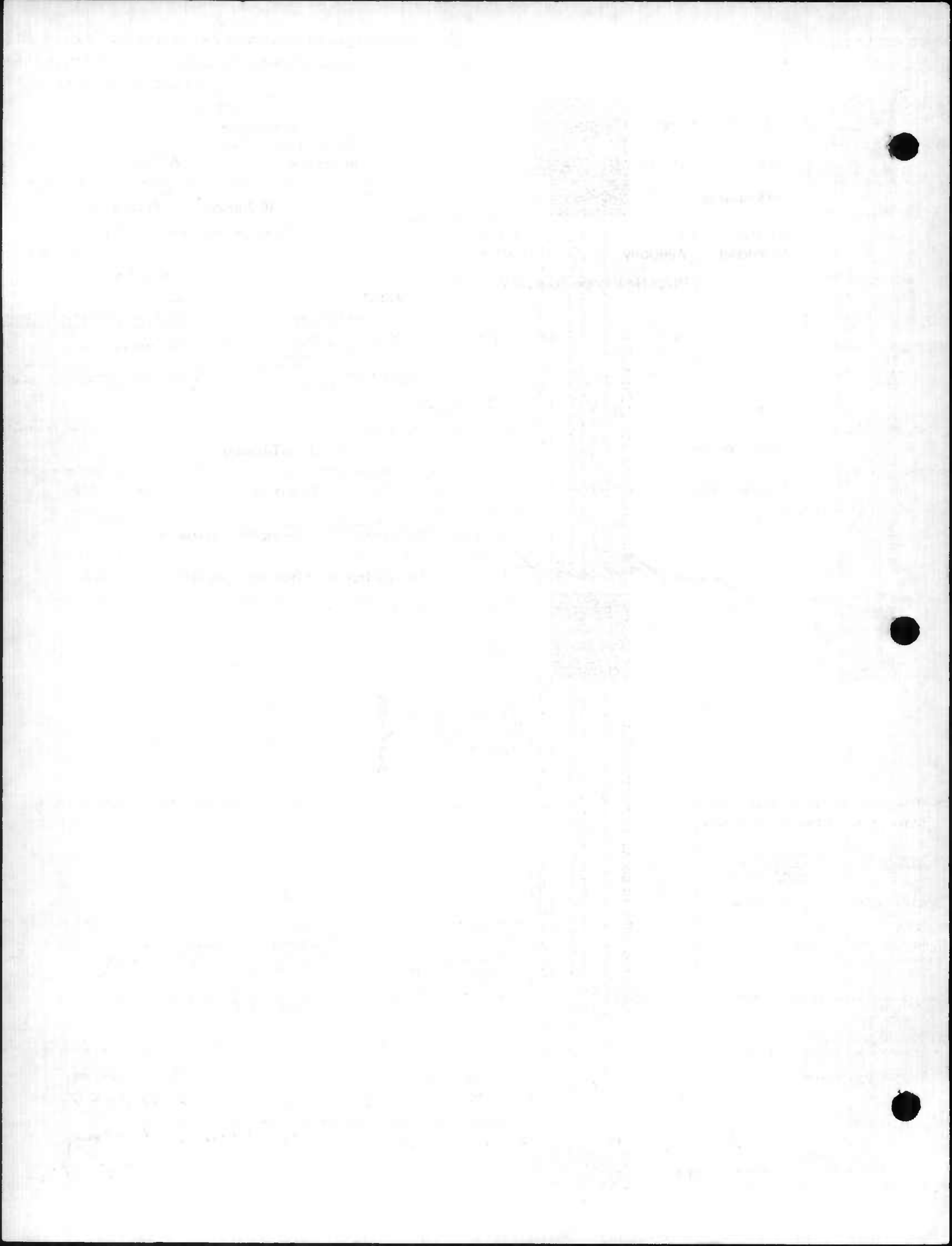
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

State
Registrar

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38643

| | | | | | | | | |
|--|--|--|--|---|--|---------------------------------|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) NORMA LEE STEVENS | | | | 2. Date of Death Month DECEMBER Day 7 Year 1997 | | 3. Time of Death 11:55 AM | |
| | 4a. Facility Name (If not institution, give street and number) Johns Hopkins Hospital | | | | 4b. City, Town, or Location of Death BALTIMORE | | 4c. County of Death N/A | |
| Funeral Director | 5. Social Security Number 220-26-9979 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 66 Yrs. | | 8. Date of Birth (Month, Day, Year) 15-Jan-31 | |
| | 9. Birthplace (State or Foreign Country) Maryland | | 10a. State Maryland | | 10b. County Allegany | | 10c. City, Town or Location Frostburg | |
| To Be Completed by Funeral Director | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 10e. Street and Number 18224 Borden Yard Road, N.W. | | 10f. Zip Code 21532- | |
| | 10g. Citizen of What Country? U.S.A. | | | | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | |
| | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: White | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 0 | |
| | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker | | | | 16b. Kind of Business/Industry Homemaker | | | |
| | 17. Father's Name (First, Middle, Last) Winard Blank | | | | 18. Mother's Name (First, Middle, Maiden Surname) Evelyn Williams | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Darrell Stevens Husband | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18224 Borden Yard Road Frostburg Maryland 21532- | | | |
| | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Frostburg Memorial Park | | 20c. Location - City or Town, State 10-Dec-97 Frostburg, Maryland | |
| | 21. Signature of Funeral Service Licensee  | | | | 22. Name and Address of Facility Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | Approximate Interval Between Onset and Death WEEKS DAYS WEEKS | | | |
| | 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 23c. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day Year) 10-Dec-97 | | 28b. Time of Injury M | | |
| 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | 28d. Describe how injury occurred | | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. Signature and title of certifier  | | | | |
| 29c. License number B64976811 | | | | 29d. Date signed (Month, Day, Year) DECEMBER 7, 1997 | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) STEVEN B. GOLDIN M.D. Johns Hopkins Hospital | | | | 31. Date filed (Month, Day, Year) DEC 09 1997 | | | | |
| 32. Registrar's Signature  | | | | 33. State Registrar DEC 09 1997 | | | | |

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

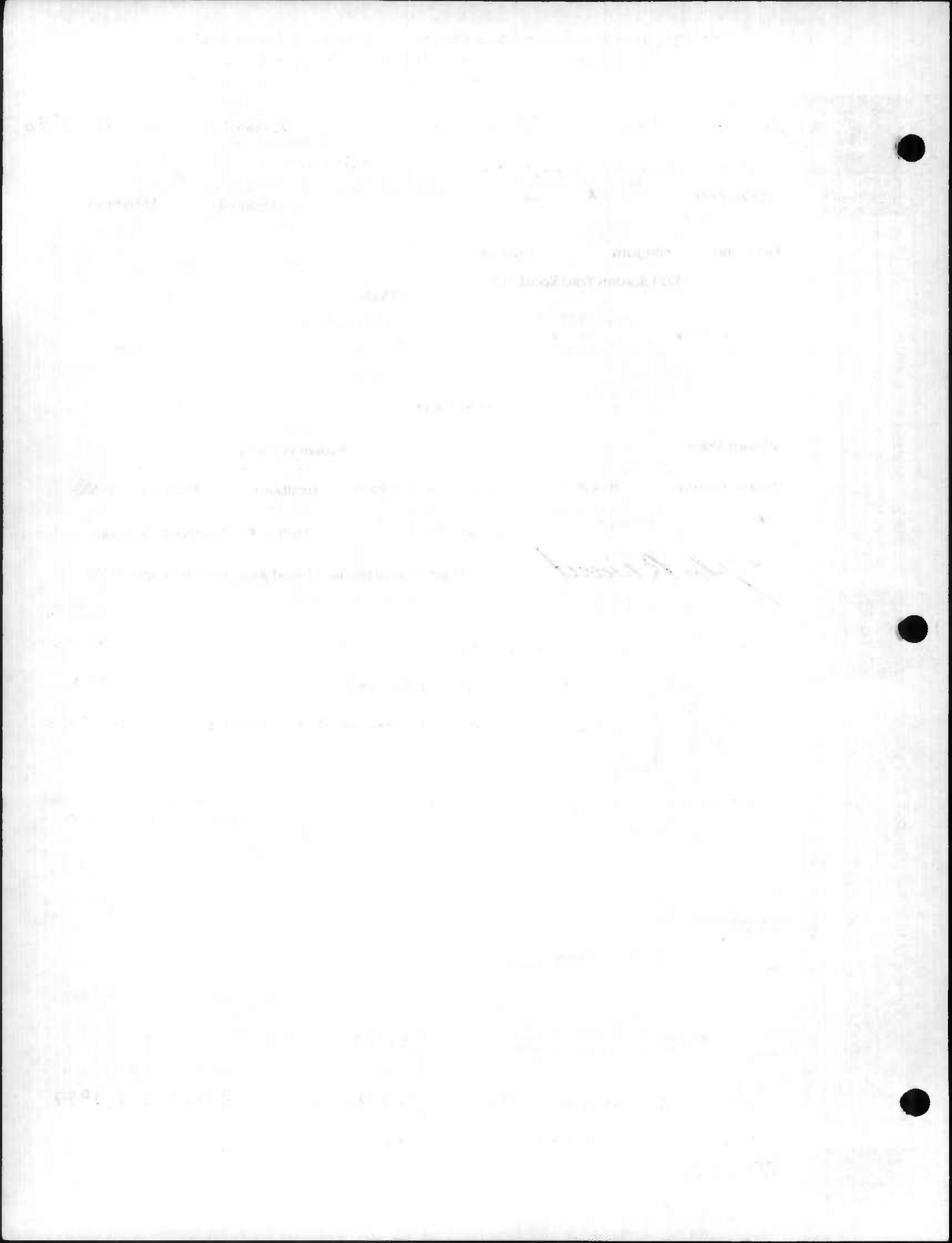
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 38644

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Philip Andrew Shewbridge

2. Date of Death

Month Day Year
DECEMBER 7 1997

3. Time of Death

12:41 PM

4a. Facility Name (If not institution, give street and number)

Sacred Heart Hospital

4b. City, Town, or Location of Death

Cumberland,

4c. County of Death

Allegany

5. Social Security Number

219-03-8611

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

76

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Nov. 19, 1921

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Allegany

10c. City, Town or Location

Nikep

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

17632 Better End Road

10f. Zip Code

21539

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give

Year or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Labor

16b. Kind of Business/Industry

Brewing

17. Father's Name (First, Middle, Last)

Harrison M. Shewbridge

18. Mother's Name (First, Middle, Maiden Surname)

Ellen Deitz

19a. Informant's Name/Relationship (Type, Print)

Carrie Shewbridge wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

17632 Better End Road Nikep, MD 21539

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Rocky Gap Cemetery

Date

Dec. 10
1997

20c. Location - City or Town, State

Cumberland, MD

21. Signature of Funeral Service Licensee

James E McKenzie

22. Name and Address of Facility

Eichhorn McKenzie Funeral Home

8 E. Main Street Lonaconing, MD 21539

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

e. Respiratory Failure

Due to (or as a consequence of):

b. END STAGE CHRONIC OBSTRUCTIVE PULMONARY DISEASE

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

48 HOURS.

20 YEARS

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

PERFORATED Duodenal ULCER

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 8 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

S. Chang MD

29c. License number

D25638

29d. Date signed (Month, Day, Year)

DECEMBER 8, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

SATURNINA CHANG MD RT-36 FROSTBURG PLAZA, FROSTBURG MARYLAND 21532

31. Date filed (Month, Day, Year)

DEC 10 1997

32. Registrar's Signature

John A. ...

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 23e-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

97 38645

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Bonnie J. Selby | | | | 2. DATE OF DEATH MONTH 12 DAY 5 YEAR 1997 | | 3. TIME OF DEATH 8:00 a.m. | |
| 4. SOCIAL SECURITY NUMBER 217-28-1497 | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 65 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) April 29, 1932 | |
| 8. BIRTHPLACE (State or Foreign Country) W.VA | | | | 9a. FACILITY NAME (If not institution, give street and number) 6030 Conover Rd. | | 9b. CITY, TOWN OR LOCATION OF DEATH Taneytown | |
| 9c. COUNTY OF DEATH Carroll | | | | 10a. STATE MD | | 10b. COUNTY Carroll | |
| 10c. CITY, TOWN OR LOCATION Taneytown | | | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER 6030 Conover Rd. | |
| 10f. ZIP CODE 21787 | | | | 10g. CITIZEN OF WHAT COUNTRY? USA | | 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) 9 Elementary/Secondary (0-12) College (1-4 or 5+) | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Owner- Operator | | 16b. KIND OF BUSINESS/INDUSTRY Restaurant | |
| 17. FATHER'S NAME (First, Middle, Last) Jonah Wolford | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Sarah Moyers | | | |
| 19a. INFORMANT'S NAME (Type/Print) Francis Selby, Husband | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6030 Conover Rd. Taneytown, MD 21787 | | | |
| 20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Pipe Creek Cemetery | | 20c. LOCATION — City or Town, State 12/8/97 Linwood, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Richard Little | | | | 22. NAME AND ADDRESS OF FACILITY Littles' F.H. 34 Maple Ave. Littlestown, PA 17340 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → lung cancer DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death 3 months | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | |
| 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 28d. DESCRIBE NOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Mare A. Hirsch | | | | 29c. LICENSE NUMBER M0037694-G | | 29d. DATE SIGNED (Month, Day, Year) December 5th, 1997 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Mare A. Hirsch md- 67 George Street Hanover PA 17331 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) DEC 09 1997 | | | | 32. REGISTRAR'S SIGNATURE Julia Shuckler-Rodell | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 6876

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 5 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38646

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

LAURA BELLE TOULSON

2. Date of Death

Month Day Year
December 8 1997

3. Time of Death

0800

4a. Facility Name (If not institution, give street and number)

18576 Crown Stone Rd.

4b. City, Town, or Location of Death

Marydel

4c. County of Death

Caroline

Funeral
Director

5. Social Security Number

213-22-8923

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

72 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Mar 23, 1925

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Caroline

10c. City, Town or Location

Marydel

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

18576 Crown Stone Rd.

10f. Zip Code

21649

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

17. Father's Name (First, Middle, Last)

David L. Kenton

18. Mother's Name (First, Middle, Maiden Surname)

Ruth Ann Wyatt Kenton

19a. Informant's Name/Relationship (Type, Print)

Luther Toulson/spouse

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

18576 Crown Stone Rd., Marydel, MD 21649

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Burrsville Cemetery

Date

12/12/97

20c. Location - City or Town, State

Denton, Maryland

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

Fleagle & Helfenbein Funeral Home
106 W. Sunset Ave., Greensboro, MD

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ARTERIO-SCLEROTIC CARDIO VASCULAR Disease ACUTE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DIABETES MELLITUS - insulin dependent
HYPOTHYROIDISM
HYPERTENSION

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Christian A. Jensen MD

29c. License number

D14664

29d. Date signed (Month, Day, Year)

12/9/97

30. Name and address of person who completes cause of death (Item 23e) (Type, Print)

C.E. JENSEN MD, BOX 690, DENTON MD 21629

31. Date filed (Month, Day, Year)

DEC 11 '97

32. Registrar's Signature

Julia Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

0070

The first part of the report is

CHAPTER II
THE SECOND PART OF THE REPORT

CHAPTER III
THE THIRD PART OF THE REPORT

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

Reg. No.

87 38647

| | | | | | | | | |
|---|--|--|---|--|--|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) <div style="text-align: center;">SARA TRUITT WILLIAMS</div> | | | | 2. Date of Death Month Day Year December 6 1997 | | 3. Time of Death 1635 | |
| | 4a. Facility Name (If not institution, give street and number) PENINSULA REGIONAL MEDICAL CENTER | | | | 4b. City, Town, or Location of Death SALISBURY | | 4c. County of Death WICOMICO | |
| Funeral Director | 5. Social Security Number 215-07-5099 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 80 Yrs. | | 8. Date of Birth (Month, Day, Year) OCT. 17, 1917 | |
| | 9. Birthplace (State or Foreign Country) MARYLAND | | 10a. State MD | | 10b. County WICOMICO | | 10c. City, Town or Location SALISBURY | |
| To Be Completed by Funeral Director | Usual Residence of Decedent | | | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| | 10e. Street and Number 3973 DEVONSHIRE DR. | | | | 10f. Zip Code 21804 | | 10g. Citizen of What Country? U.S.A. | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER | | 16b. Kind of Business/Industry OWN HOME | | | |
| | 17. Father's Name (First, Middle, Last) MAURICE T. TRUITT | | | | 18. Mother's Name (First, Middle, Maiden Surname) HAZEL DRYER | | | |
| | 19a. Informant's Name/Relationship (Type, Print) ARTHUR E. WILLIAMS - HUSBAND | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3973 DEVONSHIRE DR. SALISBURY, MD 21804 | | | |
| | 20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) CAMBRIDGE CREMATORY | | Date 12-8-97 | | 20c. Location - City or Town, State CAMBRIDGE, MD | |
| | 21. Signature of Funeral Service Licensee B. Keith Phipps, CFSP | | | | 22. Name and Address of Facility BOUNDS FUNERAL HOME 705 E. MAIN ST. SALISBURY, MD 21804 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. Mixed Cell Malignant Lymphoma Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last f. Due to (or as a consequence of): g. Due to (or as a consequence of): h. Due to (or as a consequence of): | | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | |
| | | | | | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 28. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | | | 28d. Describe how injury occurred | | | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | |
| | 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the causa(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the causa(s) and manner as stated. | | 29b. Signature and title of certifier Joseph N. Grosso MD | | 29c. License number D 20507 | | 29d. Date signed (Month, Day, Year) 12/7/97 | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Joseph N. Grosso 145 E. Carroll St SALISBURY MD | | | | | | | |
| State Registrar | 31. Date filed (Month, Day, Year) DEC 08 1997 | | | | 32. Registrar's Signature Julia Anderson-Randall | | | |

Baltimore, Maryland 21215-0020
 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
 Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,
 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

ELSIE G. WALLS

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 38648

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Elsie Gertrude Walls

2. Date of Death

Month Day Year
DECEMBER 11, 1997

3. Time of Death

10:47 AM

4a. Facility Name (If not institution, give street and number)

KENT- QUEEN ANNE HOSPITAL

4b. City, Town, or Location of Death

CHESTERTOWN

4c. County of Death

KENT

Funeral
Director

5. Social Security Number

222-22-3835

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

71 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
July 5 1926

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Queen Anne

10c. City, Town or Location

Barclay

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street end Number

211 Ingleside Road

10f. Zip Code

21607

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

07

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

homemaker

16b. Kind of Business/Industry

N/A

17. Father's Name (First, Middle, Last)

Clarence Powell

18. Mother's Name (First, Middle, Maiden Surname)

Myrtle Bell Powell

19a. Informant's Name/Relationship (Type, Print)

Lois C. Walls, daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

308 Academy Ave. Denton, Maryland 21629

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Greensboro Cemetery

Date

12/14

20c. Location - City or Town, State

Greensboro, Maryland

21. Signature of Funeral Service Licensee

Fleagle & Helfenbein Funeral Home

22. Name and Address of Facility

P.O. Box 160 Greensboro, MD 21639

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Multiple Injuries
Due to (or as a consequence of):

Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient2 ☒ Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

12/10/97

28b. Time of Injury

10:03A

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

motor vehicle collision

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

street

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Rt 19 & Rt 301

Queen Anne's Co, Md

29a. Certifier (Check only one)

1 ☐ Certifying Physician2 ☒ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Dennis J. Chute, MD

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

DECEMBER 12, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Dennis Chute M.D.

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

DEC 12 '97

32. Registrar's Signature

John Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 38649

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Kenneth Rowe

2. Date of Death

12/4/97

3. Time of Death

7:42 PM

4a. Facility Name (If not institution, give street and number)

PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death

SALISBURY

4c. County of Death

WICOMICO

Funeral
Director

5. Social Security Number

218-16-8546

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

73

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

10/12/1924

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Somerset

10c. City, Town or Location

Princess Anne

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

29656 Widdowson Lane

10f. Zip Code

21853

10g. Citizen of What Country?

U.S.

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify:

White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Mail Carrier

16b. Kind of Business/Industry

Postal Service

17. Father's Name (First, Middle, Last)

Clay Widdowson

18. Mother's Name (First, Middle, Maiden Surname)

Esther Leibrand

19a. Informant's Name/Relationship (Type, Print)

Ruth Widdowson/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

29656 Widdowson Lane, Princess Anne, Md. 21853

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Beechwood Cemetery

Date

12/07/97

20c. Location - City or Town, State

Princess Anne, Md.

21. Signature of Funeral Service Licensee

James D. Human 00295

22. Name and Address of Facility

Hinman Funeral Home

11673 Somerset Ave., Princess Anne, Md. 21853

23a. Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Cerebrovascular Accident

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

4 hrs

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Carcinoma of the Esophagus

Coronary Heart Disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

David Carroll, MD

29c. License number

D26278

29d. Date signed (Month, Day, Year)

12-4-97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

David Carroll, MD 145 E. Carroll St Salisbury, MD 21801

31. Date filed (Month, Day, Year)

DEC - 5 1997

32. Registrar's Signature

John D. Carroll

State
Registrar

Baltimore, Maryland 21215-0020

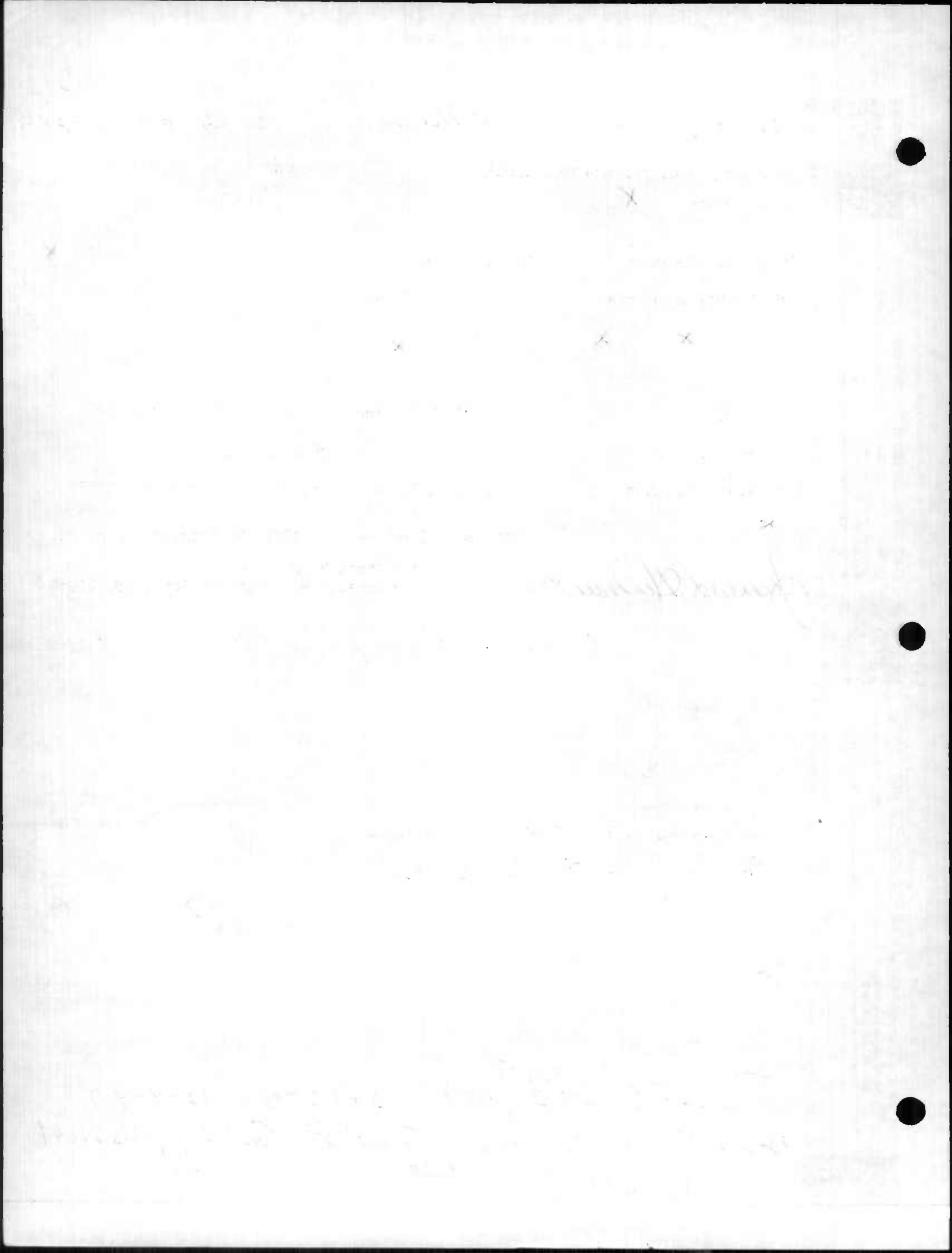
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



MAGALEIAN ANTHONY

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

ASP

Items: 23 part I, 27, 28a-f Per MEO G-755 1/2/98

Certificate of Death

Reg. No. 97 38650

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician
/Medical
ExaminerFuneral
DirectorPhysician
/Medical
Examiner

| | | | | | |
|--|--|---|---|--|---|
| 1. Decedent's Name (First, Middle, Last) MAGALEIAN ANTHONY | | 2. Date of Death Month DECEMBER Day 16 Year 1997 | | 3. Time of Death 11:45 P | |
| 4a. Facility Name (If not institution, give street and number) LIBERTY MEDICAL CENTER | | | 4b. City, Town, or Location of Death BALTIMORE | | 4c. County of Death N/A |
| 5. Social Security Number 218-64-0518 | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 41 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) JAN. 14, 1956 |
| 9. Birthplace (State or Foreign Country) MARYLAND | | | | | |
| 10a. State MARYLAND | | 10b. County N/A | | 10c. City, Town or Location BALTIMORE CITY | |
| 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number 3407 FAIRVIEW AVENUE | | | |
| 10f. Zip Code 21215 | | 10g. Citizen of What Country? U.S.A. | | | |
| 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | |
| 14. Race - American Indian, Black, White, etc. Specify: NEGRO | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) N/A College (1-4or 5+) 1 YEAR | | | |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) NURSING ASSISTANT | | 16b. Kind of Business/Industry NURSING HOME | | | |
| 17. Father's Name (First, Middle, Last) JERRY ANTHONY | | | 18. Mother's Name (First, Middle, Maiden Surname) BERTHA DAVIS | | |
| 19a. Informant's Name/Relationship (Type, Print) GERLIENE WARD/ sister | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 502 mountain road fallston, md. 21047 | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) KING MEM. PARK | | 20c. Location - City or Town, State DEC. 22, 1997 BALTO, MD. | |
| 21. Signature of Funeral Service Licensee <i>Calvin B. Scruggs Sr.</i> | | 22. Name and Address of Facility CALVIN B. SCRUGGS FUNERAL HOME 1412 e. preston street BALTO, MD 21213 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. NORTRIPTYLINE AND ALCOHOL INTOXICATION a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | | | | |
| 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | |
| 24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) found 12/16/97 | | 28b. Time of Injury found 10:30 | |
| 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how Injury occurred Unknown | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Found: Residence | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3407 Fairview Ave. Baltimore, Md. | | | |
| 29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | |
| 29b. Signature and title of certifier <i>Maureen Dore Hall</i> | | 29c. License number O.C.M.E | | 29d. Date signed (Month, Day, Year) DECEMBER 17, 1997 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D. Rysoun A. Koron 111 Penn Street, Baltimore, Maryland 21201 | | | | | |
| 31. Date filed (Month, Day, Year) DEC 23 1997 | | 32. Registrar's Signature <i>John Anderson</i> | | | |

SECRET
NO FORN DISSEM
NO UNCLASSIFIED DISSEM

Report of [illegible]

SECRET

NOV 5 1981

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38651

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

John J. AYRES, Sr.

2. Date of Death
Month Day Year
December 20, 19973. Time of Death
12:37 pmFuneral
Director

4a. Facility Name (If not Institution, give street and number)

Franklin Square Hospital Center

4b. City, Town, or Location of Death

Rosedale

4c. County of Death

Baltimore

5. Social Security Number

215-28-8760

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

66

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month Day Year)
June 3, 1931

9. Birthplace (State or Foreign Country)

Bradshaw, Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Baltimore County

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

9018 Simms Avenue

10f. Zip Code

21234

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give

Year or Dates: Korean

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

N/A

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Truck Driver

16b. Kind of Business/Industry

American Stone Co.

17. Father's Name (First, Middle, Last)

Charles Ayres

18. Mother's Name (First, Middle, Maiden Surname)

Annie Addison

19a. Informant's Name/Relationship (Type, Print)

Camilla P. Ayres (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9018 Simms Avenue Baltimore, Maryland 21234

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

St. Joseph's Church Cem. December 23, 1997

Date

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Balthasar Bessah Chojmicki

22. Name and Address of Facility

Lassahn Funeral Home, Inc.

7401 Belair Road Baltimore, Maryland 21236-4625

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a. Perforated Viscus (perforated Ulcer)

2 Days

Due to (or as a consequence of):

b. Upper Gastrointestinal Bleed

3 Days

Due to (or as a consequence of):

c. Renal Failure

Due to (or as a consequence of):

d. Chronic Obstructive Pulmonary Disease

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Hamilton Small

29c. License number

RD2125

29d. Date signed (Month, Day, Year)

December 20, 1997

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

Hamilton Small M.D. 9000 Franklin Square Drive Baltimore, Maryland 21237

State
Registrar

31. Date filed (Month, Day, Year)

DEC 23 1997

32. Registrar's Signature

Julia Davidson-Randall

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23a-4 show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38652

Physician
/Medical
ExaminerFuneral
Director

| | | | | | | | |
|---|--|---|--|--|---------------------------------|--|--|
| 1. Decedent's Name (First, Middle, Last) Carrie T. Austin | | | | 2. Date of Death Month: December, Day: 17, Year: 1997 | | 3. Time of Death 8:15 AM | |
| 4a. Facility Name (If not institution, give street and number) 7236 Martelle Avenue | | | | 4b. City, Town, or Location of Death Dundalk | | 4c. County of Death Baltimore | |
| 5. Social Security Number 212-09-7365 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 100 Yrs. | If Under 1 Year Months: Days: | If Under 24 Hrs. Hours: Min. | 8. Date of Birth (Month, Day, Year) 1897 | |
| 9. Birthplace (State or Foreign Country) Virginia | | | | | | | |
| Usual Residence of Decedent | | | | | | | |
| 10a. State Maryland | | 10b. County Baltimore | | 10c. City, Town or Location Dundalk | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| 10e. Street and Number 7236 Martelle Avenue | | | | 10f. Zip Code 21222 | | 10g. Citizen of What Country? United States | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 8 Years | | | | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Spice Department | | 16b. Kind of Business/Industry Manufacturing | |
| 17. Father's Name (First, Middle, Last) George L. Sheplett | | | | 18. Mother's Name (First, Middle, Maiden Surname) Susan A. Madison | | | |
| 19a. Informant's Name/Relationship (Type, Print) Beatrice Hall/Daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7236 Martelle Ave. Dundalk, MD 21222 | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Oak Lawn Cemetery | | Date 12/20/1997 | | 20c. Location - City or Town, State Baltimore, Maryland | |
| 21. Signature of Funeral Service Licensee <i>Chad M. Felt</i> | | | | 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 | | | |

To Be Completed by Funeral Director

Physician
/Medical
Examiner

| | | |
|---|--|--|
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>natural ASCVD</i> | | Approximate Interval Between Onset and Death <i>years</i> |
| Due to (or as a consequence of): | | |
| b. Due to (or as a consequence of): | | |
| c. Due to (or as a consequence of): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last d. Due to (or as a consequence of): | | |

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

encephalopathy
history of coronary artery disease
history of peripheral vascular disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural
2 ☐ Accident
3 ☐ Suicide
4 ☐ Homicide5 ☐ Pending investigation
6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury
M28c. Injury at Work?
1 ☐ Yes 2 ☒ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Kathy Travis MD

29c. License number

D52631

29d. Date signed (Month, Day, Year)

12/17/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

*Johns Hopkins Endicott Center - Terrace Level
5505 Hopkins Bayview Circle, Baltimore, MD 21224*

31. Date filed (Month, Day, Year)

DEC 23 1997

32. Registrar's Signature

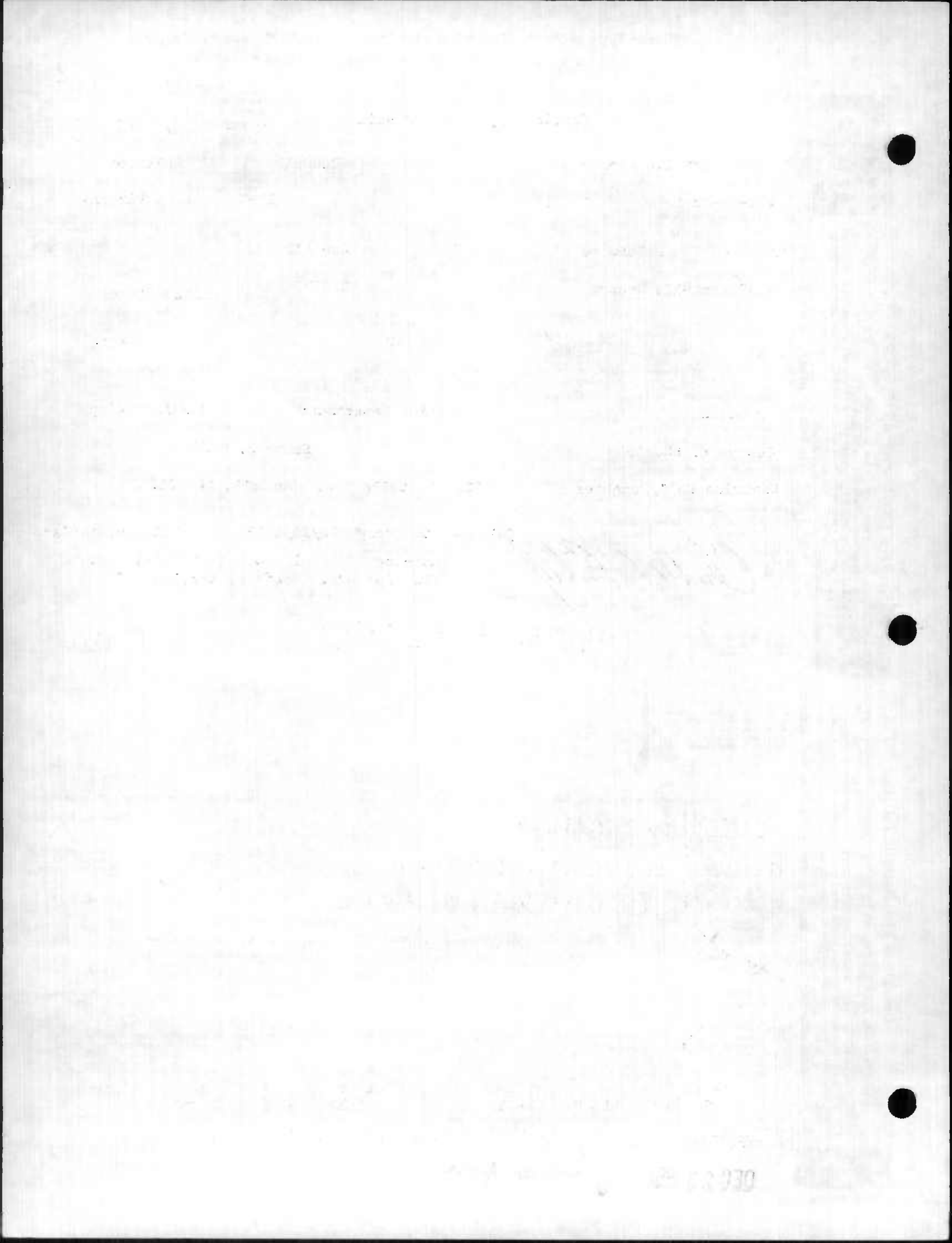
*Julia Davidson-Randall*State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit card.

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38653

Item: 20b per FH G-754 12/30/97 dh

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

DOROTHY

ABICHT

2. Date of Death

DECEMBER 22, 1997

3. Time of Death

12:20 AM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Saint Joseph Medical Center

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

5. Social Security Number

213-10-8228

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

85

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

March 6 1912

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Towson

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2300 Dulaney Valley Rd.

10f. Zip Code

21204

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☐ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

n/a

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Secretary

16b. Kind of Business/Industry

General Elevator

17. Father's Name (First, Middle, Last)

Rufus Foy

18. Mother's Name (First, Middle, Maiden Surname)

Annie Griffin

19a. Informant's Name/Relationship (Type, Print)

Patricia Lee Kramer/daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

527 Penny Lane, Cockeysville, MD 21030

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)Lorraine Park Cemetery
Dulaney Valley Memorial Gardens

Date

12/24/97

20c. Location - City or Town, State

Timonium, MD 21093

21. Signature of Funeral Service Licensed

Michael J. Flagle

22. Name and Address of Facility

Lemmon Funeral Home

10 W. Padonia Rd., Timonium, MD 21093

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

SEPSIS

e.

Due to (or as a consequence of):

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Sequently list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) LastApproximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

SPINAL CORD TUMOR

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24e. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicidal 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

M

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Michael J. Flagle

29c. License number

D37254

29d. Date signed (Month, Day, Year)

12/22/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BOON P. LIM, M.D., 7620 YORK ROAD, TOWSON, MARYLAND 21204

31. Date filed (Month, Day, Year)

DEC 23 1997

32. Registrar's Signature

Julia Davidson-Randall

State
Registrar

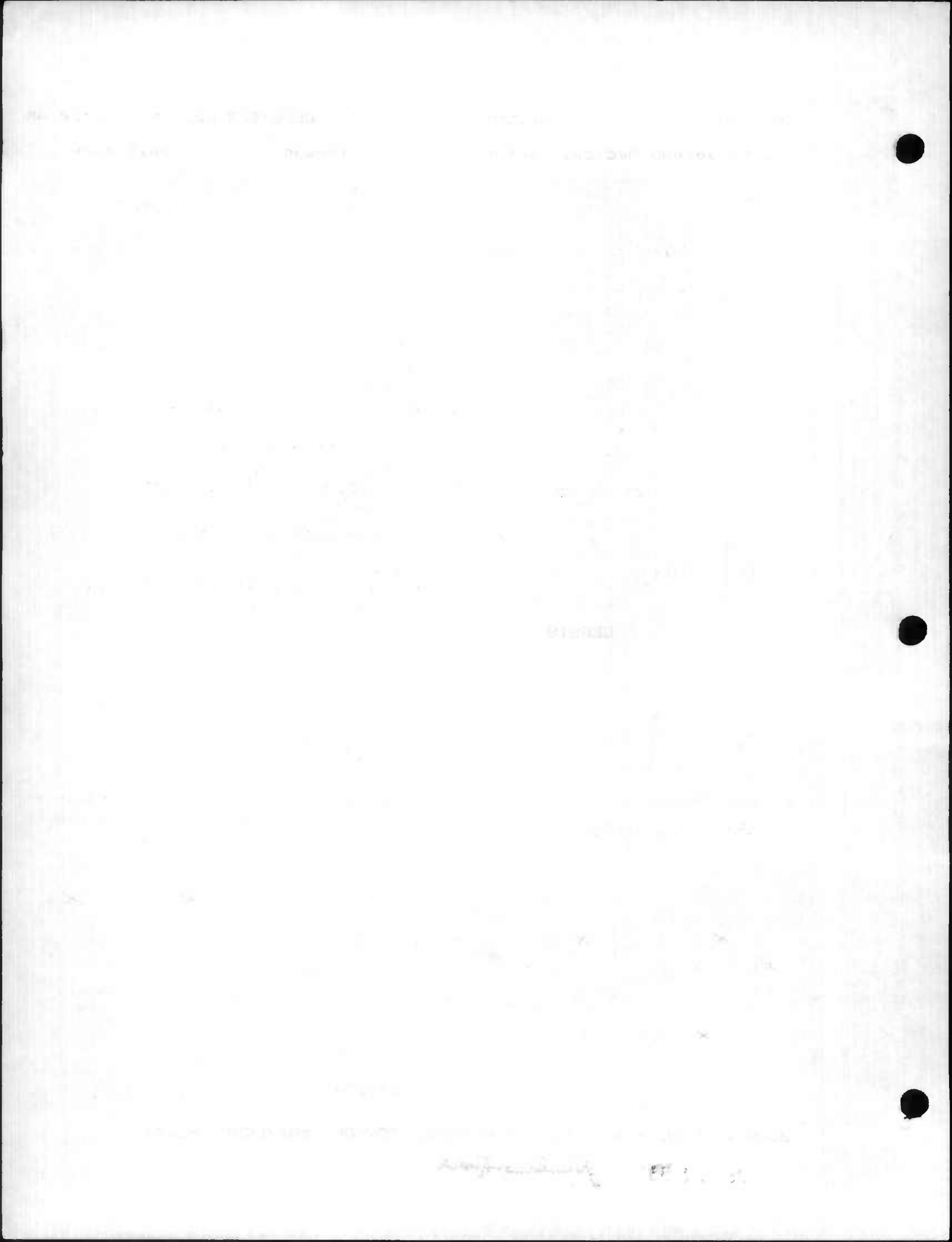
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Items#0,10e per FH G754 12/23/97 EW

97 38654

Physician
/Medical
Examiner

Funeral
Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 505-555-5555.

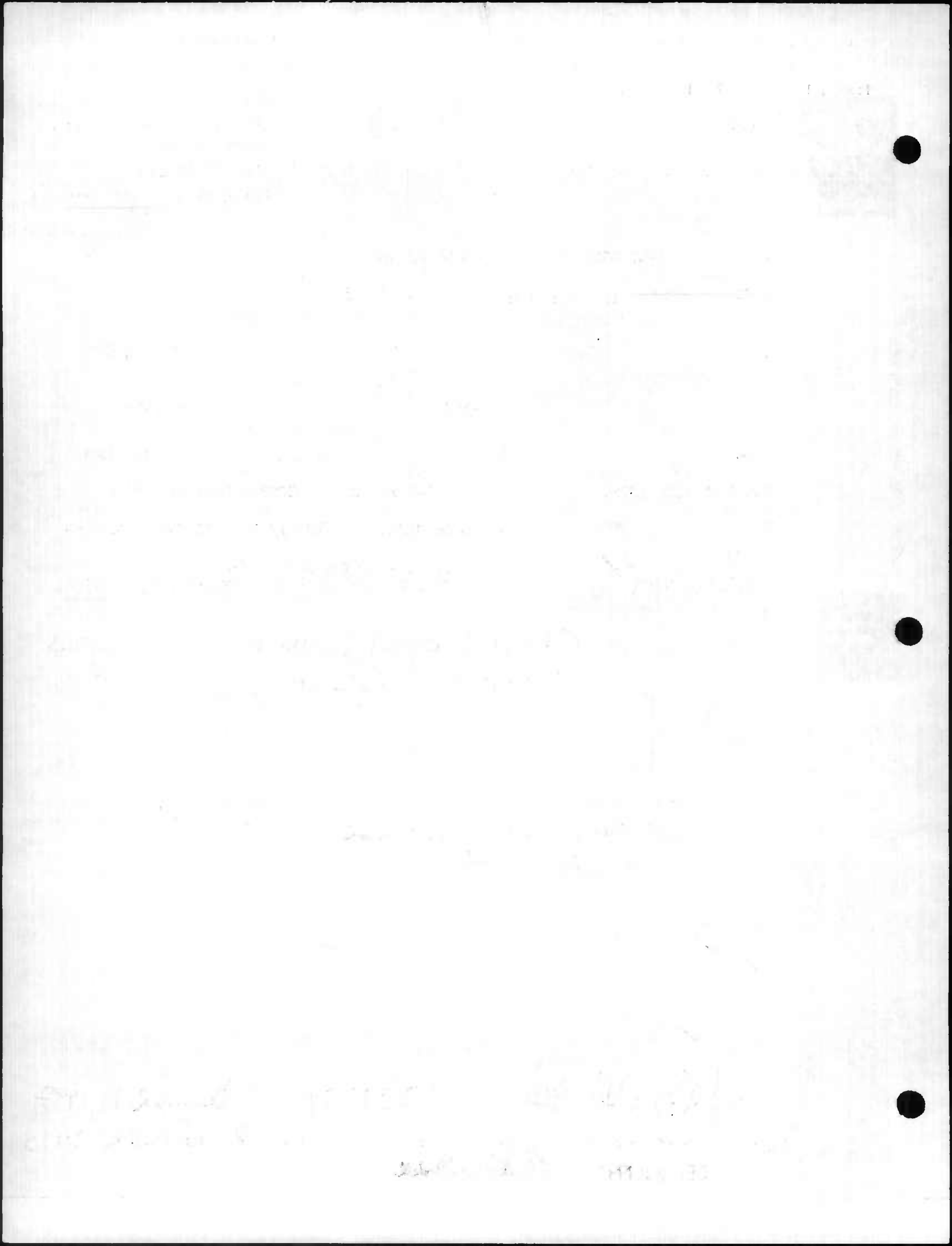
Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | | | | |
|--|--|---|--|---|--|--|--|
| 1. Decedent's Name (First, Middle, Last) JEROME J ASCH | | | | 2. Date of Death Month DEC. Day 18 Year 1997 | | 3. Time of Death 9:15 PM | |
| 4a. Facility Name (If not institution, give street and number) CHERRYWOOD NURSING HOME | | | | 4b. City, Town, or Location of Death REISTERSTOWN | | 4c. County of Death BALTIMORE | |
| 5. Social Security Number 410-26-9591 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 74 Yrs. | | 8. Date of Birth (Month, Day, Year) JUNE 9, 1923 | |
| 9. Birthplace (State or Foreign Country) TENNESSEE | | 10. Usual Residence of Decedent | | 11. Decedent's Education (Specify only highest grade completed) | | 12. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | |
| 10a. State MD | | 10b. County BALTIMORE | | 10c. City, Town or Location REISTERSTOWN | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10e. Street and Number 11 SEBASTIAN CT. | | | | 10f. Zip Code 21136 | | 10g. Citizen of What Country? USA | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 2 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) SALES | | 16b. Kind of Business/Industry GARMENT | | 17. Father's Name (First, Middle, Last) CHARLES ASCH | |
| 18. Mother's Name (First, Middle, Maiden Surname) MIRIAM FRIEDMAN | | 19a. Informant's Name/Relationship (Type, Print) MITCHELL ASCH (SON) | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11 SEBASTIAN CT. REISTERSTOWN, MD 21136 | | 20. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | |
| 21. Signature of Funeral Service Licensee <i>Jay Allen</i> | | 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN RD., PIKESVILLE, MD 21208 | | 23a. Pertinent disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Chronic Renal Failure Due to (or as a consequence of): Renal Cell Carcinoma | | Approximate Interval Between Onset and Death 3yrs | |
| 24. Immediate Cause (Final disease or condition resulting in death) Chronic Renal Failure | | 25. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Renal Cell Carcinoma | | 26. Due to (or as a consequence of): Chronic Renal Failure | | 27. Due to (or as a consequence of): Renal Cell Carcinoma | |
| 28. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Coronary Artery Disease | | 29. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | 30. Were en autopsies performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 31. Were autopsies findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 32. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 33. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 34. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 35. Date of Injury (Month, Day, Year) DEC 18 1997 | |
| 36. Date of Injury (Month, Day, Year) DEC 18 1997 | | 37. Time of Injury M | | 38. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 39. Describe how injury occurred | |
| 40. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 5310 Old Court Road Randallstown MD 21133 | | 41. Location (Street and Number or Rural Route Number, City or Town, State) 5310 Old Court Road Randallstown MD 21133 | | 42. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 43. Signature and title of certifier <i>Jay Allen</i> | |
| 44. License number D27034 | | 45. Date signed (Month, Day, Year) DECEMBER 19, 1997 | | 46. Name and address of person who completed cause of death (Item 23e) (Type, Print) Tra Copeland MD | | 47. Date filed (Month, Day, Year) DEC 23 1997 | |
| 48. Registrar DEC 23 1997 | | 49. Signature of Registrar <i>Jay Allen</i> | | 50. Signature of Medical Examiner <i>Jay Allen</i> | | 51. Signature of Funeral Director <i>Jay Allen</i> | |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Items: 23 part I, 27, 28a-f per MEO G-757 3/26/98

Reg. No.

38655

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

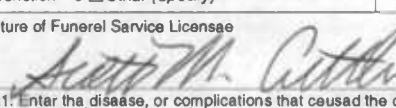
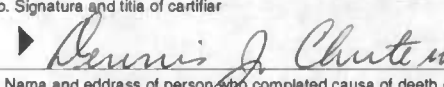
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | | |
|---|--|---|---|--|---|
| 1. Decedent's Name (First, Middle, Last) GREGORY AARON ANSHEL | | 2. Date of Death Month DECEMBER Day 18 Year 1997 | | 3. Time of Death 08:44 AM | |
| 4a. Facility Name (If not institution, give street and number) HOWARD COUNTY GENERAL HOSPITAL | | 4b. City, Town, or Location of Death COLUMBIA | | 4c. County of Death HOWARD | |
| 5. Social Security Number 213-51-7990 | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) Yrs. 1 Months 14 Days 14 | 8. Date of Birth (Month, Day, Year) OCT. 24, 1997 | | 9. Birthplace (State or Foreign Country) MARYLAND |
| Usual Residence of Decedent | | | | | |
| 10a. State MD | 10b. County HOWARD | 10c. City, Town or Location LAUREL | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10e. Street and Number 7529 COLUMBIA PIKE | | 10f. Zip Code 20723 | | 10g. Citizen of What Country? USA | |
| 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | |
| 14. Race - American Indian, Black, White, etc. WHITE | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) NONE College (1-4or 5+) NONE | | | |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) NONE | | 16b. Kind of Business/Industry NONE | | | |
| 17. Father's Name (First, Middle, Last) HEATH LANE ANSHEL | | 18. Mother's Name (First, Middle, Maiden Surname) STEPHANIE CATHERINE BOWERS | | | |
| 19a. Informant's Name/Relationship (Type, Print) HEATH ANSHEL (FATHER) | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7529 COLUMBIA PIKE LAUREL, MD 20723 | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) OHEB SHALOM MEM PARK | | 20c. Location - City or Town, State 12/21/97 REISTERSTOWN, MD | |
| 21. Signature of Funeral Service Licensee  | | 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN RD., PIKESVILLE, MD 21208 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. MALNUTRITION Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | |
| 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | |
| 24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) Found 12/18/97 | | 28b. Time of Injury 8:00 AM | |
| 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred Malnourished | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Found at home | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) 7529 Columbia Pike Laurel, Md. | | | |
| 29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | |
| 29b. Signature and title of certifier  | | 29c. License number OCME | | 29d. Date signed (Month, Day, Year) DECEMBER 18, 1997 | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Dennis J. Chute, MD 111 Penn Street, Baltimore, Maryland 21201 | | | | | |
| 31. Date filed (Month, Day, Year) DEC 23 1997 | | 32. Registrar's Signature  | | | |

State
Registrar

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

Funeral
Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | | |
|--|--|---|---|--|--|
| 1. Decedent's Name (First, Middle, Last) Martha E. ALBAN | | 2. Date of Death Month December Day 17 , Year 1997 | | 3. Time of Death 6:48 am | |
| 4a. Facility Name (If not institution, give street and number) Franklin Square Hospital Center | | | 4b. City, Town, or Location of Death Rosedale | | 4c. County of Death Baltimore |
| 5. Social Security Number 220-30-0234 | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 66 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) May 21, 1931 |
| 9. Birthplace (State or Foreign Country) Md. | | | | | |
| Usual Residence of Decedent | | | | | |
| 10a. State Md. | 10b. County Baltimore | 10c. City, Town or Location Essex | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 10e. Street and Number 1101 H Queens Purchase Road | | | 10f. Zip Code 21221 | | 10g. Citizen of What Country? USA |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | |
| 14. Race - American Indian, Black, White, etc. Specify: White | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8th College (1-4 or 5+) | | | |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Housekeeping | | 16b. Kind of Business/Industry Hospital | | | |
| 17. Father's Name (First, Middle, Last) Charles Kellner | | | 18. Mother's Name (First, Middle, Maiden Surname) Mary Zorn | | |
| 19a. Informant's Name/Relationship (Type, Print) Betsy Aikaterinidis/daughter | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 207 Rolling Knoll Drive Belair, Md. 21014 | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Oak Lawn Cemetery | | 20c. Location - City or Town, State 12/19/97 Baltimore, Md. | |
| 21. Signature of Funeral Service Licensee R. Terry Connelly | | 22. Name and Address of Facility Connelly Funeral Home of Essex 300 Mace Avenue Baltimore, Md. 21221 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Conductive Heart Failure | | | | | |
| 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | |
| 23c. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 23d. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Schizophrenia Adenocarcinoma of the breast | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | |
| 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | |
| 29b. Signature and title of certifier Robert S. Kuznetsov | | 29c. License number 038933 | | 29d. Date signed (Month, Day, Year) 12/18/97 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robert S. Kuznetsov 104 Plumtree Rd. St 102 Bel Air MD 21015 | | | | | |
| 31. Date filed (Month, Day, Year) DEC 23 1997 | | 32. Registrar's Signature John Davidson-Randall | | | |

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38657

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

Dorothy Brodie

2. Date of Death

Month Day Year

December 20, 1997

3. Time of Death

5:15 PM

4a. Facility Name (If not institution, give street and number)

Joseph Richey Hospice

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

5. Social Security Number

217-30-3575

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

80 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

2 10 17

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD.

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

6717 Town Brook Dr. #D

10f. Zip Code

21207

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify:

Afro-American

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

11 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

John Wade

18. Mother's Name (First, Middle, Maiden Surname)

Agnes Johnson

19a. Informant's Name/Relationship (Type, Print)

Ms. Evelyn Brodie (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8927 Groffs Mill Dr. Owings Mill, Md. 21117

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Arbutus Memorial PK.

Date

12/27/97

20c. Location - City or Town, State

Baltimore, Md.

21. Signature of Funeral Service Licensee

Joseph L. Russ

22. Name and Address of Facility

Joseph L. Russ

2222 W. North Ave

Baltimore, Md.

21216

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. PANCREATIC CARCINOMA

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 YEAR

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

STAGE 2 ADENOCARCINOMA LEFT COLON

CONGESTIVE HEART FAILURE

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

HOSPICE

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Donna L. Lachman

29c. License number

D06933

29d. Date signed (Month, Day, Year)

12/21/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JAN B MAC GIBSON MD 101 WRENS ST WITET19 BALTIMORE MD 21201

31. Date filed (Month, Day, Year)

DEC 9 3 1997

32. Registrar's Signature

John Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. If item 27 is marked other than "natural", or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

97-7233-510

B.K.S

NOEL BLAIR

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 38658

Certificate of Death

Reg. No.

| | | | | | | | | | | |
|--|--|--|--|--|---|--|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) NOEL A. BLAIR | | | | 2. Date of Death Month Day Year DEC. 16, 1997 | | | | 3. Time of Death 0331 AM | |
| | 4a. Facility Name (If not institution, give street and number) SINAI HOSPITAL I.C.U | | | | 4b. City, Town, or Location of Death BALTIMORE | | | | 4c. County of Death NA | |
| Funeral Director | 5. Social Security Number 214-47-0669 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 15 Yrs. | | 8. Date of Birth (Month, Day, Year) Jul 12 1982 | | 9. Birthplace (State or Foreign Country) JAMAICA | |
| | Usual Residence of Decedent | | | | 10a. State MD | | 10b. County NA | | 10c. City, Town or Location BALTIMORE | |
| To Be Completed by Funeral Director | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | 10e. Street and Number 3710 W. BELVEDERE AVE. | | | | 10f. Zip Code 21215 | |
| | 10g. Citizen of What Country? JAMAICA | | | | 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | |
| | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: JAMAICAN | | | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9th College (1-4 or 5+) NA | |
| | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DD NDT use retired) NA | | | | 16b. Kind of Business/Industry NA | | | | 17. Father's Name (First, Middle, Last) ABRAHAM MATTHEWS | |
| | 18. Mother's Name (First, Middle, Maiden Surname) MYRTLE SHAND | | | | 19a. Informant's Name/Relationship (Type, Print) ABRAHAM MATTHEWS-FATHER | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3710 W. BELVEDERE AVE. BALTO., MD 21215 | |
| Physician /Medical Examiner | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) KING MEMORIAL PARK | | | | 20c. Location - City or Town, State 12-22-97 RANDALLSTOWN, MD | |
| | 21. Signature of Funeral Service Licensee  | | | | 22. Name and Address of Facility MARCH FUNERAL HOME-WEST 4300 WABASH AVE. BALTO., MD 21215 | | | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Gunshot wound of abdomen Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): | |
| | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | 24e. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| | 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | 27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | |
| | 28a. Date of Injury (Month, Day, Year) 12-15-97 | | | | 28b. Time of Injury 855 M | | | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 28d. Describe how Injury occurred Subject shot | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) 5700 Highgate Dr. | | | | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Certifying Physician: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | |
| | 29b. Signature and title of certifier  | | | | 29c. License number O.C.M.E | | | | 29d. Date signed (Month, Day, Year) DEC. 16, 1997 | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J. Lakon | | | | 31. Date filed (Month, Day, Year) DEC 23 1997 | | | | 32. Registrar's Signature  | |
| | 31. Date filed (Month, Day, Year) DEC 23 1997 | | | | 32. Registrar's Signature  | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38659

| | | | | | | | | | | | | |
|--|---|--|--|--|---|--|---|--|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) John G. Bonds | | | | 2. Date of Death Month Day Year December 13, 1997 | | | | 3. Time of Death 10:45 PM | | | |
| | 4a. Facility Name (If not institution, give street and number) Manor Care | | | | 4b. City, Town, or Location of Death Baltimore | | | | 4c. County of Death n/a | | | |
| Funeral Director | 5. Social Security Number 224-24-7231 | | 6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 75 Yrs. | | 8. Date of Birth (Month, Day, Year) July 2, 1922 | | 9. Birthplace (State or Foreign Country) Virginia | | | |
| | Usual Residence of Decedent | | | | 10a. State Md. | | | | 10b. County n/a | | | |
| To Be Completed by Funeral Director | 10c. City, Town or Location Baltimore | | | | 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | 10e. Street and Number 3724 Columbus Drive | | | |
| | 10f. Zip Code 21215 | | | | 10g. Citizen of What Country? USA | | | | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | |
| | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 1943 | | | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: Black | | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 6th Grade | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Long Shoreman | | | | 16b. Kind of Business/Industry ILA-STA | | | |
| | 17. Father's Name (First, Middle, Last) Henry Bonds | | | | 18. Mother's Name (First, Middle, Maiden Surname) Thelma Dickerson | | | | 19a. Informant's Name/Relationship (Type, Print) Raymond Bonds son | | | |
| | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3724 Columbus Drive Baltimore, Md. 21215 | | | | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Garrison Forest Veterans | | | |
| | 20c. Location - City or Town, State Dec. 19 Owings Mills, Md. | | | | 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility Nutter Funeral Homes, Inc. 2501 Gwynns Falls PKWY Baltimore, Md. 21216 | | | |
| | 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Cardiomyopathy Due to (or as a consequence of): 100M Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): | | | | Approximate Interval Between Onset and Death 1 yr. | | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PVD | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day, Year) | | | | 28b. Time of Injury M | | | | |
| 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | 28d. Describe how injury occurred | | | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. Signature and title of certifier | | | | 29c. License number 037573 | | | |
| | 29d. Date signed (Month, Day, Year) December 19, 1997 | | | | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Jef Zibell MD 7220 Park Heights Ave Baltimore MD 21208 | | | | 31. Date filed (Month, Day, Year) DEC 23 1997 | | | |
| | 32. Registrar's Signature | | | | | | | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 38660

| | | | | | | | | | |
|--|---|--|---|--|--|--|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) JOHN LEROY BOOKER | | | | 2. Date of Death Month Day Year DEC. 20, 1997 | | 3. Time of Death 4:00 P.M. | | |
| | 4a. Facility Name (If not institution, give street and number) 700 OLD STAGE ROAD | | | | 4b. City, Town, or Location of Death GLEN BURNIE | | 4c. County of Death ANNE ARUNDEL | | |
| Funeral Director | 5. Social Security Number 213-28-8223 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 67 Yrs. | | 8. Date of Birth (Month, Day, Year) 6/18/1930 | | |
| | 9. Birthplace (State or Foreign Country) MD | | 10. Usual Residence of Decedent 10a. State MD 10b. County ANNE ARUNDEL 10c. City, Town or Location GLEN BURNIE | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | |
| 10e. Street and Number 700 OLD STAGE ROAD | | 10f. Zip Code 21061 | | 10g. Citizen of What Country? U.S.A. | | | | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) MAINTENANCE | | 16b. Kind of Business/Industry A.A. COUNTY | | | | | |
| 17. Father's Name (First, Middle, Last) GEORGE BOOKER | | | | 18. Mother's Name (First, Middle, Maiden Surname) MARGARET WAGNER | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) JUNE B. BOOKER | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 700 OLD STAGE ROAD, GLEN BURNIE, MD 21061 | | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) GLEN HAVEN CEM. | | 20c. Date 12/24 | | 20d. Location - City or Town, State GLEN BURNIE, MD | | | |
| 21. Signature of Funeral Service Licensee  | | | | 22. Name and Address of Facility RAYMOND C. FINK FUNERAL HOME 426 CRAIN HWY., SW., GLEN BURNIE, MD 21061 | | | | | |
| 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. Myocardial Infarction Due to (or as a consequence of): b. Myocardial Artery Aneurysm Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | | | | | | | Approximate Interval Between Onset and Death | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | |
| | | | | | | 24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicida <input type="checkbox"/> Homicida | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier  | | 29c. License number D33296 | | 29d. Date signed (Month, Day, Year) 12/22/97 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NEIL E PADGETT 1111 QUARTERFIELD RD, GLEN BURNIE MARYLAND 21061 | | | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 23 1997 | | 32. Registrar's Signature  | | | | | | | |

Baltimore, Maryland 21215-0020

Physician Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. The first part of the report deals with the general situation of the country and the progress of the work during the year. It is a summary of the work done and the results achieved. It is a general statement of the work done and the results achieved.

2. The second part of the report deals with the specific work done during the year. It is a detailed statement of the work done and the results achieved. It is a detailed statement of the work done and the results achieved.

3. The third part of the report deals with the financial statement of the year. It is a statement of the income and expenditure of the year. It is a statement of the income and expenditure of the year.

4. The fourth part of the report deals with the general statement of the work done and the results achieved. It is a general statement of the work done and the results achieved. It is a general statement of the work done and the results achieved.

5. The fifth part of the report deals with the general statement of the work done and the results achieved. It is a general statement of the work done and the results achieved. It is a general statement of the work done and the results achieved.

6. The sixth part of the report deals with the general statement of the work done and the results achieved. It is a general statement of the work done and the results achieved. It is a general statement of the work done and the results achieved.

7. The seventh part of the report deals with the general statement of the work done and the results achieved. It is a general statement of the work done and the results achieved. It is a general statement of the work done and the results achieved.

8. The eighth part of the report deals with the general statement of the work done and the results achieved. It is a general statement of the work done and the results achieved. It is a general statement of the work done and the results achieved.

9. The ninth part of the report deals with the general statement of the work done and the results achieved. It is a general statement of the work done and the results achieved. It is a general statement of the work done and the results achieved.

10. The tenth part of the report deals with the general statement of the work done and the results achieved. It is a general statement of the work done and the results achieved. It is a general statement of the work done and the results achieved.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38661

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Marion Barton

2. Date of Death

December 19, 1997

3. Time of Death

8:30am

4a. Facility Name (If not institution, give street and number)

Johns Hopkins Bayview Medical Ctr.

4b. City, Town, or Location of Death

Baltimore City

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

217-18-1082

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

75

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Dec. 31, 1921

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Dundalk

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2027 Frames Road

10f. Zip Code

21222

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☐ No

If Yes, Give Year or Dates: 1948-51

13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (14 or 5+)

10 Years

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Herman A. Fiske

18. Mother's Name (First, Middle, Maiden Surname)

Amelia Ritter

19a. Informant's Name/Relationship (Type, Print) Son

Mr. Robert E. Barton, Jr.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2027 Frames Road Dundalk, Maryland 21222

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Holly Hill Mem. Gdns. 12/22/1997

Date

20c. Location - City or Town, State

Middle River, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Duda-Ruck Funeral Home of Dundalk, Inc.

7922 Wise Ave. Dundalk, Maryland 21222

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a. Cerebral Edema

Due to (or as a consequence of):

b. Intraventricular Hemorrhage

Due to (or as a consequence of):

c. Hypertension

Due to (or as a consequence of):

d. Cerebrovascular disease

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Coronary Artery Disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation
6 ☐ Could not be determined28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

Louise McCullough, MD/PhD

96709

December 19th, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Louise D. McCullough, MD, PhD, Johns Hopkins Bayview,
Baltimore, Maryland.

31. Date filed (Month, Day, Year)

DEC 23 1997

32. Registrar's Signature

John Anderson

State
Registrar

Baltimore, Maryland 21215-0020

Permit: Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23b show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit
certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Items: 9, 18, 19b per FH G-754 12/30/97 dh

97 38662

| | | | | | |
|--|--|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Marjorie R. Bishop | | 2. Date of Death Month December Day 19 , Year 1997 | | 3. Time of Death 10:27 p.m. |
| | 4a. Facility Name (If not institution, give street and number) 2 Spindrift Circle Apt. F | | 4b. City, Town, or Location of Death Parkville | | 4c. County of Death Baltimore |
| Funeral Director | 5. Social Security Number 016-30-1996 | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 57 Yrs. | If Under 1 Year Months 57 Days 57 | 8. Date of Birth (Month, Day, Year) Feb. 4, 1940 |
| | 9. Birthplace (State or Foreign Country) Salem, MA | | 10. Usual Residence of Decedent | | |
| 10a. State Md. | | 10b. County N/A | 10c. City, Town or Location Baltimore City | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| 10e. Street and Number 4515 Schenley Road | | 10f. Zip Code 21210 | | 10g. Citizen of What Country? United States | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | |
| 14. Race - American Indian, Black, White, etc. Specify: White | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Manager | |
| 16b. Kind of Business/Industry Food Service | | 17. Father's Name (First, Middle, Last) Rosario La Pointe | | 18. Mother's Name (First, Middle, Maiden Surname) Anna M. Madeau Nadeau | |
| 19a. Informant's Name/Relationship (Type, Print) Lisa A. Carson (Daughter) | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 900 Apt. B Swallow Cr. St. Edgewood. Maryland 21040 | | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Hilltop Service Corp. | | 20c. Location - City or Town, State 12/22/97 Towson Maryland | |
| 21. Signature of Funeral Service Licensee Milton J. Knight Jr. | | 22. Name and Address of Facility Leonard J. Ruck, Inc. 5305 Harford Road Baltimore, Md. 21214 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. OVARIAN CANCER Due to (or as a consequence of): PERIPHERAL VASCULAR DISEASE Due to (or as a consequence of): BREAST CANCER Due to (or as a consequence of): | | Approximate Interval Between Onset and Death 3 1/2 yrs 3 1/4 yr. 2 3/4 yrs. | | | |
| 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | 23c. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | |
| 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier Dr. Joseph Buscema, M.D. ATTENDING PHYSICIAN | | 29c. License number D25274 | |
| 29d. Date signed (Month, Day, Year) DECEMBER 22, 1997 | | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Dr. Joseph Buscema, M.D. 6565 N. Charles St. Towson, Maryland | | | |
| 31. Date filed (Month, Day, Year) DEC 23 1997 | | 32. Registrar's Signature John Davidson-Rodell | | | |

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

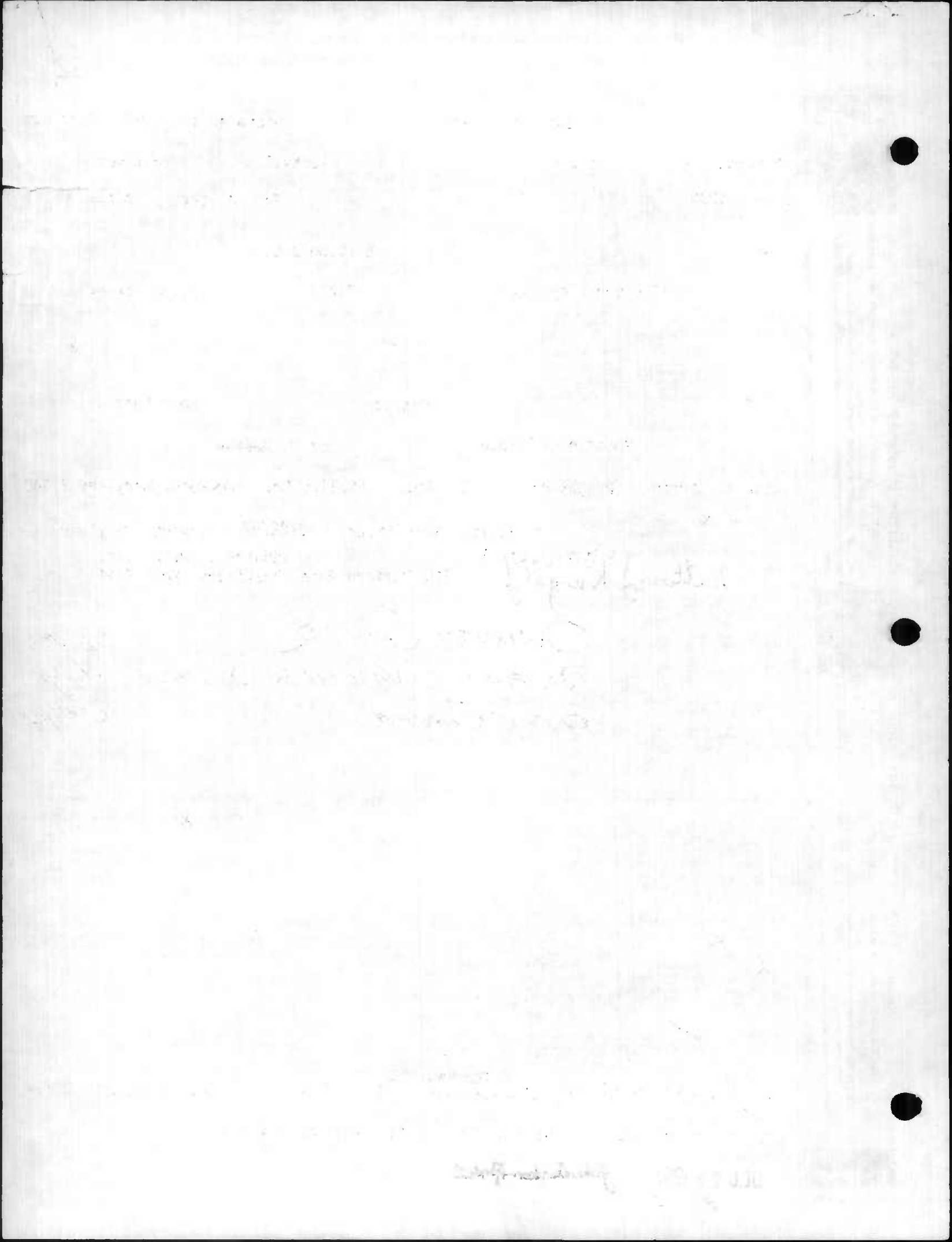
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23e show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38663

| | | | | | | | | |
|--|---|--|---|---|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Robert Paul Brown, Sr. | | | | 2. Date of Death Month Day Year DECEMBER 22, 1997 | | 3. Time of Death 11:35 AM | |
| | 4a. Facility Name (If not institution, give street and number) Saint Joseph Medical Center | | | | 4b. City, Town, or Location of Death Towson | | 4c. County of Death Baltimore | |
| Funeral Director | 5. Social Security Number 219-22-9281 | 6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 71 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) Sept 15, 1926 | | 9. Birthplace (State or Foreign Country) Maryland |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State Maryland | | 10b. County Baltimore | | 10c. City, Town or Location Lutherville | | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| 10e. Street and Number 225 Division Avenue | | | | 10f. Zip Code 21093 | | 10g. Citizen of What Country? USA | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 1946 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) n/a | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Installer | | | 16b. Kind of Business/Industry Communications | |
| 17. Father's Name (First, Middle, Last) Harvey Paul Brown, Sr. | | | | 18. Mother's Name (First, Middle, Maiden Surname) Katherine Doerer | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Elise M. Brown/Wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 225 Division Avenue, Lutherville, Maryland 21093 | | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Dulaney Valley Mem. Grdns. | | 20c. Location - City or Town, State Timonium, Maryland | | |
| 21. Signature of Funeral Service Licensed Bryan W. Clary | | | | 22. Name and Address of Facility Lemmon Funeral Home 10 W. Padonia road, Timonium, Maryland 21093 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) STAGE IV NON SMALL CELL LUNG CARCINOMA Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): | | | | | | | | Approximate Interval Between Onset and Death 1 YEAR |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CHRONIC OBSTRUCTIVE PULMONARY DISEASE IDIOPATHIC PULMONARY FIBROSIS | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |
| | | | | 28d. Describe how injury occurred | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | |
| | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | 29b. Signature and title of certifier Beatriz P. Dizon, M.D. | | | | |
| | | | | 29c. License number D 16492 | | 29d. Date signed (Month, Day, Year) Dec. 22, 1997 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BEATRIZ P. DIZON, M.D., 7620 YORK ROAD, TOWSON, MD. 21204 | | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 23 1997 | | | | 32. Registrar's Signature John Davidson-Randall | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Page 22 of 22

1990-1991

1990-1991

1990-1991

1990-1991

1990-1991

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 38664

Physician
/Medical
Examiner

Funeral
Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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Physician
/Medical
Examiner

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To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | | | | |
|--|--|---|--|--|--------------------------------|--|--|
| 1. Decedent's Name (First, Middle, Last) Grace M. Bosley | | | | 2. Date of Death Day Month Year December 18, 1997 | | 3. Time of Death 5:27 PM | |
| 4a. Facility Name (If not institution, give street and number) Good Samaritan Hospital | | | | 4b. City, Town, or Location of Death Baltimore | | 4c. County of Death N/A | |
| 5. Social Security Number 213-16-9009 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 79 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) Oct. 6, 1918 | |
| 9. Birthplace (State or Foreign Country) Maryland | | | | | | | |
| Usual Residence of Decedent | | | | | | | |
| 10a. State Maryland | | 10b. County Baltimore | | 10c. City, Town or Location Baltimore | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| 10e. Street and Number 9508 Ronleigh Drive | | | | 10f. Zip Code 21234 | | 10g. Citizen of What Country? U.S.A. | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th grade College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Clerk | | 16b. Kind of Business/Industry Department Store | |
| 17. Father's Name (First, Middle, Last) John G. Goodwin | | | | 18. Mother's Name (First, Middle, Maiden Surname) Rose Coogan | | | |
| 19a. Informant's Name/Relationship (Type, Print) Norma Jean Weber (daughter) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9508 Ronleigh Drive, Baltimore, MD 21234 | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Most Holy Redeemer Cem. | | Date 12/22/97 | | 20c. Location - City or Town, State Baltimore, Maryland | |
| 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility Schimunek Funeral Homes, Inc. 9705 Belair Rd., Baltimore, MD 21236 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. MYOCARDIAL INFARCTION Due to (or as a consequence of): b. CORONARY ARTERY DISEASE Due to (or as a consequence of): c. HYPERLIPIDEMIA Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | | | | | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | |
| 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 28d. Describe how injury occurred | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. Signature and title of certifier | | | | 29c. License number D25010 | | 29d. Date signed (Month, Day, Year) 12/22/97 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SERENA NOLAN, MD 8035A HANFORD RD BALTIMORE MD 21234 | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 23 1997 | | | | 32. Registrar's Signature | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **97 38665**
Certificate of Death

Reg. No.

Physician
/Medical
Examiner

Funeral
Director

| | | | | |
|---|--|---|--|--|
| 1. Decedent's Name (First, Middle, Last) Clayton Teal Berry | | 2. Date of Death Month Dec Day 16 Year 1997 | | 3. Time of Death 6:45 Pm |
| 4e. Facility Name (If not institution, give street and number) Villa St Michael Nursing and Rehab Center Baltimore | | 4b. City, Town, or Location of Death Baltimore | | 4c. County of Death n/a |
| 5. Social Security Number 217-07-8328 | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 87 Yrs. | 8. Date of Birth (Month, Day, Year) April 19, 1910 | 9. Birthplace (State or Foreign Country) Maryland |
| Usual Residence of Decedent | | | | |
| 10a. State Maryland | 10b. County n/a | 10c. City, Town or Location Baltimore | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| 10a. Street and Number 4800 Northern Parkway | | 10f. Zip Code 21215 | | 10g. Citizen of What Country? U. S. A. |
| 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
| 14. Race - American Indian, Black, White, etc. Specify: White | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8th College (1-4or 5+) -- | | |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Policeman | | 16b. Kind of Business/Industry Martin Marietta | | |
| 17. Father's Name (First, Middle, Last) Harris Teal Berry | | 18. Mother's Name (First, Middle, Maiden Surname) Pearl Smyth | | |
| 19a. Informant's Name/Relationship (Type, Print) Elsa Clarke | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 417 Periwinkle Drive Bethany, DE 19930-9503 | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Loudon Park Cemetery December 18, 1997 Baltimore, MD | | 20c. Location - City or Town, State |
| 21. Signature of Funeral Service Licentiate  | | 22. Name and Address of Facility Loring Byers Funeral Directors, Inc. 8728 Liberty Rd. Randallstown, MD 21133-4784 | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Cerebra / Thrombosis Due to (or as a consequence of): Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | | | Approximate Interval Between Onset and Death 4 years |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |
| | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) N/A | 28b. Time of Injury M | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| | | 28d. Describe how Injury occurred | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier  | | |
| | | 29c. License number D15872 | | 29d. Date signed (Month, Day, Year) December 17, 1997 |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Harold Bobm 25 Marsh St. Randallstown 21156 | | | | |
| 31. Date filed (Month, Day, Year) DEC 23 1997 | | 32. Registrar's Signature  | | |

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Physician / Medical Examiner
Clayton Berry
Baltimore, Maryland 21215-0020
Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician / Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the Burial-Transit

Division of Vital Records, P.O. Box 68760,

3

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38666

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Isabelle BURKE

2. Date of Death
Month Day Year

December 10, 1997

3. Time of Death

12:30 P.M.

4a. Facility Name (If not institution, give street and number)

Franklin Square Hospital Center

4b. City, Town, or Location of Death

Rosedale

4c. County of Death

Baltimore

5. Social Security Number

217-20-2071

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

71

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
10/17/26

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Md

10b. County

Baltimore

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7913 St. Claire Lane

10f. Zip Code

21222

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No.

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

sixth grade

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Assembly line

16b. Kind of Business/Industry

R.E. Michael

17. Father's Name (First, Middle, Last)

Edward Surguy

18. Mother's Name (First, Middle, Maiden Surname)

Mary Brower

19a. Informant's Name/Relationship (Type, Print)

Carroll Burke, Jr./son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7913 St. Claire Lane, Baltimore, Md 21222

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Loudon Park Cemetery

Date

12/13/97

20c. Location - City or Town, State

Baltimore

21. Signature of Funeral Service Licensee

R. Terry Connelly

22. Name and Address of Facility

Connelly Funeral Home of Essex

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Brain Metastasis

Due to (or as a consequence of):

26 hours

b. Lung Cancer

Due to (or as a consequence of):

c. Chronic Obstructive Pulmonary Disease

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation
6 ☐ Could not be determined28a. Date of Injury
(Month, Day Year)28b. Time of
injury28c. Injury at
Work?
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Khin Win Myint

29c. License number

RD2122

29d. Date signed (Month, Day, Year)

12-10-97

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

Khin Myint M.D. 9000 Franklin Square Drive, Baltimore, MD 21237

31. Date filed (Month, Day, Year)

DEC 23 1997

32. Registrar's Signature

John Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

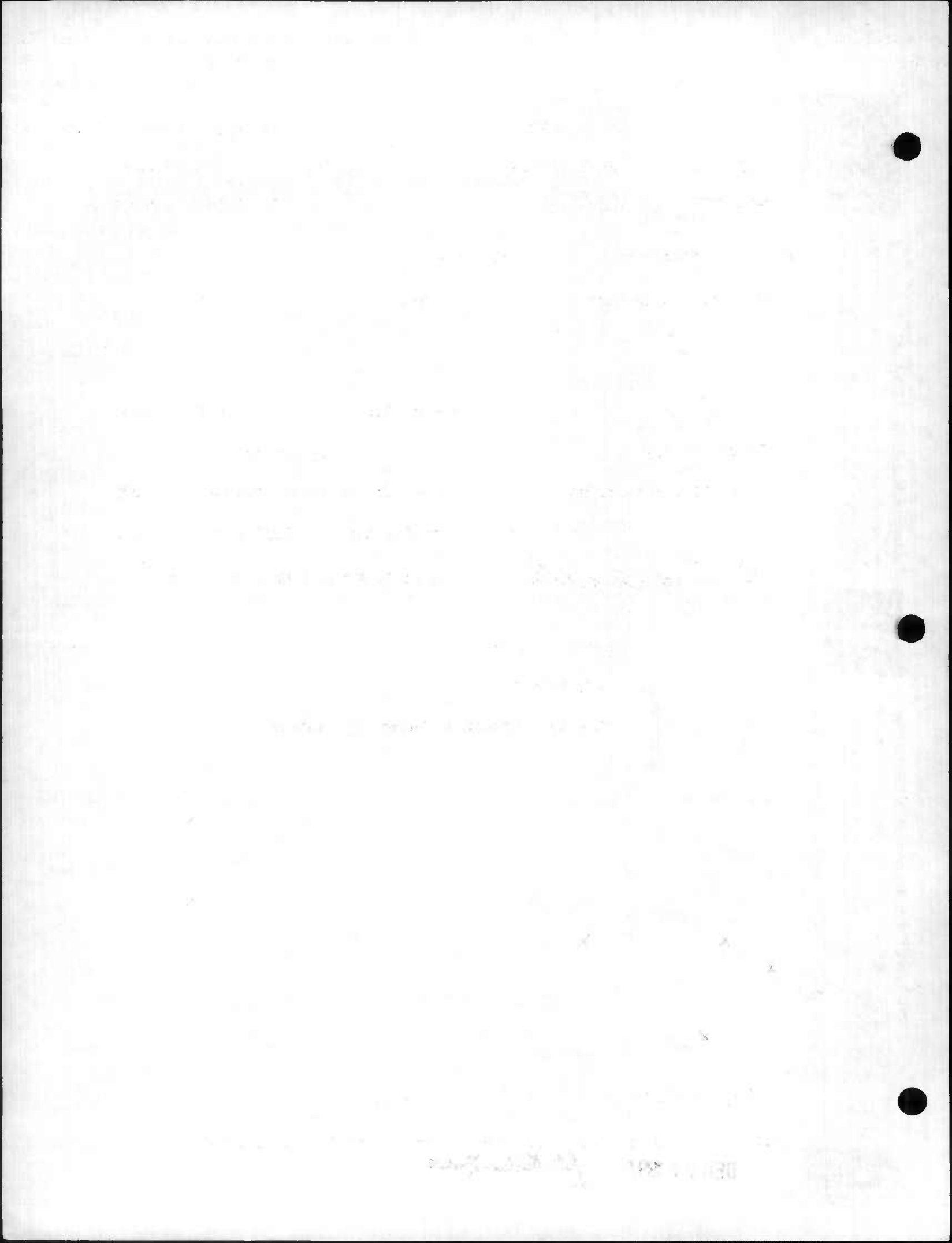
To the Hospital or Attending Physician: The law requires that the death certificate be completed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be completed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

FRANK LAWRENCE CHARTIER

Items: 23a part 1, 27 per MEO G-754 12/23/97 dh

Certificate of Death

Reg. No.

97 38667

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Physician
/Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | | |
|---|--|--|--|---|--|
| 1. Decedent's Name (First, Middle, Last) Frank Lawrence Chartier | | 2. Date of Death Month DEC. Day 13, Year 1997 | | 3. Time of Death 1405 PM | |
| 4a. Facility Name (If not institution, give street and number) NORTH ARUNDEL HOSPITAL | | 4b. City, Town, or Location of Death GLEN BURNIE | | 4c. County of Death ANNE ARUNDEL | |
| 5. Social Security Number 381-56-6025 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 46 Yrs. | |
| 8. Date of Birth (Month, Day, Year) Dec. 7, 1951 | | 9. Birthplace (State or Foreign Country) Michigan | | | |
| 10a. State MD | | 10b. County Anne Arundel | | 10c. City, Town or Location Arnold | |
| 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number 900 Lynch Drive | | 10f. Zip Code 21012 | |
| 10g. Citizen of What Country? USA | | 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | |
| 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 5+ | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Chief Financial Officer | | 16b. Kind of Business/Industry Finances | |
| 17. Father's Name (First, Middle, Last) Frank Chartier | | 18. Mother's Name (First, Middle, Maiden Surname) Elsie | | | |
| 19a. Informant's Name/Relationship (Type, Print) Deborah Chartier/wife | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 900 Lynch Drive, Arnold, MD 21012 | | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory | | 20c. Location - City or Town, State Baltimore, MD | |
| 21. Signature of Funeral Service Licensee <i>James E. Barranco</i> | | 22. Name and Address of Facility Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy., Severna Park, MD 21146 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | Approximate Interval Between Onset and Death | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | |
| 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | |
| 24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | |
| 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Certifying Physician: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | |
| 29b. Signature and title of certifier <i>[Signature]</i> | | 29c. License number O.C.M.E | | 29d. Date signed (Month, Day, Year) DEC. 15, 1997 | |
| 30. Name and address of person who completed causa of death (Item 23a) (Type, Print) David R Fowler 111 Penn Street, Baltimore, Maryland 21201 | | | | | |
| 31. Date filed (Month, Day, Year) DEC 19 1997 | | 32. Registrar's Signature <i>John Davidson-Randall</i> | | | |

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38668

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Charles

Cornish

2. Date of Death

Month Day Year
DECEMBER 16, 1997

3. Time of Death

22:38

4a. Facility Name (If not institution, give street and number)

THE JOHNS HOPKINS HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE CITY

4c. County of Death

Funeral
Director

5. Social Security Number

214-14-2465

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

78 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Sept 29, 1919

9. Birthplace (State or Foreign Country)

Md

Usual Residence of Decedent

10a. State

Md

10b. County

NA

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

1408 Northgate Road

10f. Zip Code

21218

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

7th grade

College (14 or 5+)

NA

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Laborer

16b. Kind of Business/Industry

American Smelting Refinery

17. Father's Name (First, Middle, Last)

James Cornish

18. Mother's Name (First, Middle, Maiden Surname)

Marcella Aquilla

19a. Informant's Name/Relationship (Type, Print)

Leonard Cornish - Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2309 Old Maple Court Ellicott City, Md 21042

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Cedar Hill Cem 12-20-97 Anne Arundel Co. Md

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licenses

John B. Johnson Jr.

22. Name and Address of Facility

Marshall H. West
4300 Nabash Avenue Baltimore, Md 21215

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Intraabdominal sepsis

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

3 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Perirectal Abscess

Due to (or as a consequence of):

1 week

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

28. Place of Death (Check only one)

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Eric V. Johnson, MD

29c. License number

Res-000

29d. Date signed (Month, Day, Year)

December 12, 1997

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

Eric Jackson 600 North Wolfe Street Baltimore, MD 21287-9106

31. Date filed (Month, Day, Year)

DEC 23 1997

32. Registrar's Signature

John Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

perm. 3. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38669

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Arthur E. Chambers

2. Date of Death

December 20 1997 3:42 AM

3. Time of Death

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Piering Parkway Nursing Home

4b. City, Town, or Location of Death

Parkville

4c. County of Death

Baltimore

5. Social Security Number

234-30-0219

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

73 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

January 16, 1924

9. Birthplace (State or Foreign Country)

West Virginia

Usual Residence of Decedent

10a. State
Maryland Baltimore

10b. County

10c. City, Town or Location
Parkville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1801 Wentworth Rd.

10f. Zip Code

21234

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
2 yrs

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Shipping & Receiving clerk

16b. Kind of Business/Industry

E.I.L. Instruments

17. Father's Name (First, Middle, Last)

Charles Chambers

18. Mother's Name (First, Middle, Maiden Surname)

Lillian Chaddock

19a. Informant's Name/Relationship (Type, Print)

Charles R. Chambers

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7912 Ardmore Ave. Baltimore, Maryland 21234

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Doraine Park Cemetery

Date

Dec 22 1997

20c. Location - City or Town, State

Baltimore Md

21. Signature of Funeral Service Licensee

Kirsta J. Wells

22. Name and Address of Facility

Evans Funeral Chapel
8800 Harford Rd. Baltimore, Md 21234

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Ischemic Heart Disease

Due to (or as a consequence of):

Pulmonary Artery Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Prostate Cancer

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28. Place of Death (Check only one)

Other:

4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28e. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury et Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

34190

29d. Date signed (Month, Day, Year)

Dec. 22, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Mierza 3007 Northern Parkway Baltimore, Md. 21214

31. Date filed (Month, Day, Year)

DEC 23 1997

32. Registrar's Signature

Julia Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

87 38670

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Harry S. Cummings Jr.

2. Date of Death

Month

Day

Year

12 - 26 - 97

3. Time of Death

13:59

4a. Facility Name (If not institution, give street and number)

Maryland General Hospital

4b. City, Town, or Location of Death

Baltimore City

4c. County of Death

n/a

Funeral
Director

5. Social Security Number

214-40-4478

6. Sex

M

2 F

7. Age (In yrs. last birthday)

91

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

April 4, 1906

9. Birthplace (State or Foreign Country)

Md.

Usual Residence of Decedent

10a. State

Md.

10b. County

n/a

10c. City, Town, or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1504 McCulloh Street

10f. Zip Code

21217

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

5

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Probation Officer

16b. Kind of Business/Industry

Baltimore City

17. Father's Name (First, Middle, Last)

Harry S. Cummings

18. Mother's Name (First, Middle, Maiden Surname)

Blanche Conklin

19a. Informant's Name/Relationship (Type, Print)

Louise C. Dorcas sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1504 McCulloh Street Baltimore, Md. 21217

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Arbutus Memorial Park

Date

Dec. 24

20c. Location - City or Town, State

Baltimore, Md.

21. Signature of Funeral Service Licensee

Ernest R. Cummings

22. Name and Address of Facility

Nutter Funeral Homes, Inc.

2501 Gwynns Falls PKWY Baltimore, Md. 21216

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Chronic Obstructive Lung Disease

Due to (or as a consequence of):

b. Congestive Heart Failure

Due to (or as a consequence of):

c. Aspiration Pneumonia

Due to (or as a consequence of):

d.

Approximate interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Anemia, Malnutrition.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural5 ☐ Pending investigation2 ☐ Accident6 ☐ Could not be determined3 ☐ Suicide4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Dore M.D.

29c. License number

89249

29d. Date signed (Month, Day, Year)

12/20/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sue Hague MD C/O Maryland General Hospital

31. Date filed (Month, Day, Year)

DEC 23 1997

32. Registrar's Signature

John Anderson

State
Registrar

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be completed and signed by the attending physician and the funeral director. After this certificate has been signed by the attending physician and the funeral director, page 2 should be detached for use as the burial permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 505-5.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38671

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Clifton Christian (Clarence)

2. Date of Death

Month

Day

Year

December 21 1997

3. Time of Death

10:25 PM

4a. Facility Name (If not institution, give street and number)

Baltimore Rehab Extended Care

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

5. Social Security Number

214-12-1957

6. Sex

10 M 20 F

7. Age (in yrs. last birthday)

76 Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

8. Date of Birth

(Month, Day, Year)

8-5-21

9. Birthplace (State or Foreign Country)

Baltimore

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

10 Yes 20 No

10e. Street and Number

3407 Ellamont Rd.

10f. Zip Code

21215

10g. Citizen of What Country?

USA

11. Marital Status

10 Never Married 20 Married

30 Widowed 40 Divorced

12. Was Decedent Ever in U.S. Armed Forces?

10 Yes 20 No

If Yes, Give Year or Dates: 1944-1945

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

10 Yes 20 No Specify:

A

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

N/A

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Clerk

16b. Kind of Business/Industry

Insurance

17. Father's Name (First, Middle, Last)

William Christian

18. Mother's Name (First, Middle, Maiden Surname)

Maggie Cubit

19a. Informant's Name/Relationship (Type, Print)

Beatrice Christian-wife 3407 Ellamont Rd. Baltimore, MD 21215

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3407 Ellamont Rd. Baltimore, MD 21215

20a. Method of Disposition

10 Burial 20 Cremation 30 Removal from State

40 Donation 50 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Garrison Forest

Date

12-26-97

20c. Location - City or Town, State

Owings Mills MD

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

Albert P. Wylie F/H, PA

638 N. Gilmore St. Baltimore, MD 21217

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Pancreatic Cancer

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

{

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

5-6 months

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

10 Yes 20 No 30 Probably 40 Unknown

24a. Was an autopsy performed?

10 Yes 20 No

24b. Were autopsy findings available prior to completion of cause of death?

10 Yes 20 No

25. Was case referred to medical examiner?

10 Yes 20 No

26. Place of Death (Check only one)

Hospital:

10 Inpatient 20 ER/Outpatient 30 DOA

Other:

40 Nursing Home 50 Residence 60 Other (Specify)

27. Manner of Death

10 Natural

20 Accident

30 Suicide

40 Homicide

50 Pending investigation

60 Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

10 Yes 20 No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

10 Natural

20 Medical Examiner

29b. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

D37070

29d. Date signed (Month, Day, Year)

December 22, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

David J. Lorech MD, Baltimore Rehab/Extended Care

31. Date filed (Month, Day, Year)

DEC 23 1997

32. Registrar's Signature

Julia Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38672

| | | | | | | | | |
|--|--|---|---|--|--|--------------------------------|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Irngard Cisneros | | | | 2. Date of Death Month Dec Day 20 , Year 1997 | | 3. Time of Death 4:00 am | |
| | 4a. Facility Name (If not institution, give street and number) Anne Arundel Medical Center | | | | 4b. City, Town, or Location of Death Annapolis | | 4c. County of Death Anne Arundel | |
| Funeral Director | 5. Social Security Number 572-26-4960 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 72 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) Sept 18, 1925 | 9. Birthplace (State or Foreign Country) Germany |
| | Usual Residence of Decedent | | | | | | | |
| To Be Completed by Funeral Director | 10a. State MD | | 10b. County Anne Arundel | | 10c. City, Town or Location Annapolis | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| | 10e. Street and Number 5 Hilltop Court | | | | 10f. Zip Code 21403 | | 10g. Citizen of What Country? U.S.A. | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 2 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker | | 16b. Kind of Business/Industry Own Home | | | |
| | 17. Father's Name (First, Middle, Last) Joseph Zitzmann | | | | 18. Mother's Name (First, Middle, Maiden Surname) Ana Muhr | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Richard Cisneros / son | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1889 Crownsville Road Annapolis, MD 21401 | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Hillcrest Mem. Gardens | | Date 12/22 | | 20c. Location - City or Town, State Annapolis, MD | |
| | 21. Signature of Funeral Service Licensee <i>[Signature]</i> | | | | 22. Name and Address of Facility Hardesty Funeral Home, PA 12 Ridgley Avenue, Annapolis, MD 21401 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. PNEUMONIA Due to (or as a consequence of): b. LUNG CANCER Due to (or as a consequence of): c. EMPHYSEMA Due to (or as a consequence of): d. Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | | | | |
| | 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| Physician /Medical Examiner | 23c. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | Approximate Interval Between Onset and Death 1 WK SINCE 2/97 | |
| | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | |
| | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | |
| | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | |
| | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. Describe how injury occurred | | | |
| | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| State Registrar | 29b. Signature and title of certifier <i>[Signature]</i> Dr. SEUNICK | | | | 29c. License number DO8118 | | 29d. Date signed (Month, Day, Year) 12/21/97 | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suite 300 900 BESTGATE RD ANNAPOLIS MD 21401 | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 23 1997 | | 32. Registrar's Signature <i>[Signature]</i> | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

Reg. No.

97 38673

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ROBERT E CLARK

2. Date of Death

Month Day Year
DECEMBER 21 1997

3. Time of Death

5:46 PM

4a. Facility Name (If not institution, give street and number)

Mercy Medical Center

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Baltimore City

5. Social Security Number

215-56-7919

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

48 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Nov. 28, 1949

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore City

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

10 East Lee Street, Unit 2209

10f. Zip Code

21202

10g. Citizen of What Country?

USA

11. Marital Status

☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give
Year or Dates: 1970-7213. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Systems Programmer

16b. Kind of Business/Industry

Medical

17. Father's Name (First, Middle, Last)

Robert E. Clark Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Jeanette Mary Shai

19a. Informant's Name/Relationship (Type, Print)

Carl Porta - Friend

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10 East Lee Street, Baltimore, MD 21202

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Metro Crematory

Date

12/23

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Hardesty Funeral Home, P.A.
12 Ridgely Avenue, Annapolis, MD 2140123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

e. INTRACEREBRAL HEMORRHAGE

Approximate
Interval Between
Onset and Death

HOURS

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

RESPIRATORY FAILURE

GASTROINTESTINAL HEMORRHAGE

MITRAL STENOSIS WITH ATRIAL FIBRILLATION

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation
6 ☐ Could not be determined28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, term, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

MD

29c. License number

D50016

29d. Date signed (Month, Day, Year)

DECEMBER 21, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BARBARA ALEXANDER 225 GREENE ST BALTIMORE 21201

31. Date filed (Month, Day, Year)

DEC 23 1997

32. Registrar's Signature

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38674

| | | | | | | | | |
|--|--|--|---|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) MARY M. CROSBY | | | | 2. Date of Death Month Day Year December 1, 1997 | | 3. Time of Death 2:35 AM | |
| | 4a. Facility Name (If not institution, give street and number) Colton Villa Nursing Home | | | | 4b. City, Town, or Location of Death Hagerstown | | 4c. County of Death Washington | |
| Funeral Director | 5. Social Security Number 220-10-8920 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 78 Yrs. | | 8. Date of Birth (Month, Day, Year) Aug. 7, 1919 | |
| | 9. Birthplace (State or Foreign Country) MD | | 10a. State Maryland | | 10b. County Washington | | 10c. City, Town or Location Hagerstown | |
| To Be Completed by Funeral Director | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 10e. Street and Number 750 Dual Highway | | 10f. Zip Code 21740 | | 10g. Citizen of What Country? U.S.A. | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: white | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Cook | | 16b. Kind of Business/Industry Food Services | | | |
| | 17. Father's Name (First, Middle, Last) Allen Sell | | | | 18. Mother's Name (First, Middle, Maiden Surname) Margaret Vermilya | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Dennis Crosby/son | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19 W. Cumberland St., Clearspring, MD 21722 | | | |
| | 20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Data | | 20c. Location - City or Town, State | | | |
| | 21. Signature of Funeral Service Licensee Ronald S. Wade, Director | | | | 22. Name and Address of Facility State Anatomy Board, 655 W. Baltimore Street Baltimore, MD 21201 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Huntington's Chorea - progressive Due to (or as a consequence of): b. COPD Due to (or as a consequence of): c. Recurrent aspiration pneumonia Due to (or as a consequence of): d. Approximate Interval Between Onset and Death Years Years months | | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Coronary artery disease Seizure disorder | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | |
| To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| | 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| | 29b. Signature and title of certifier J. L. Correyes, M.D. | | 29c. License number D41131 | | 29d. Date signed (Month, Day, Year) 12/16/97 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JERRY L. CORREYES, M.D. 338 MILL STREET HAGERSTOWN, MD 21740 | | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 23 1997 | | | | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 38675

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|--|---|---|---------------------------------------|--|--|---|---|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Mary H. Challenger | | | | 2. Date of Death Month December Day 11 Year 1997 | | 3. Time of Death 01:50 am | |
| | 4a. Facility Name (If not institution, give street and number) Memorial Hospital @ Easton | | | | 4b. City, Town, or Location of Death Easton | | 4c. County of Death Talbot | |
| Funeral Director | 5. Social Security Number 158-34-5506 | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 86 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) Jan. 1, 1911 | | 9. Birthplace (State or Foreign Country) Pennsylvania |
| | Usual Residence of Decedent | | | | | | | |
| To Be Completed by Funeral Director | 10a. State Maryland | 10b. County Talbot | 10c. City, Town or Location Easton | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | 10e. Street and Number 219 S. Washington Street | | | | 10f. Zip Code 21601 | | 10g. Citizen of What Country? U.S.A. | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: white | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 4 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Housewife | | 16b. Kind of Business/Industry Homemaker | | | |
| | 17. Father's Name (First, Middle, Last) John Leonard Hynson | | | | 18. Mother's Name (First, Middle, Maiden Surname) Mary Lena Bunting | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) David G. Challenger/son | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 755 Clubside Drive, Roswell, GA 30076 | | | |
| | 20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) State Anatomy Board, 655 W. Baltimore Street Baltimore, MD 21201 | | 20c. Location - City or Town, State | | 20d. Location - City or Town, State | |
| | 21. Signature of Funeral Service Licensee Ronald S. Wade, Director | | | | 22. Name and Address of Facility State Anatomy Board, 655 W. Baltimore Street Baltimore, MD 21201 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Corviox Arrest Due to (or as a consequence of): b. Ruptured Aortic Aorta Due to (or as a consequence of): c. Aneurysm Due to (or as a consequence of): d. | | | | | | | Approximate Interval Between Onset and Death MINUTES |
| | 23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Agonistic abuse | | | | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier Stanley Bysshe | | 29c. License number D 23066 | | 29d. Date signed (Month, Day, Year) 12/11/97 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) STANLEY BYSSHE MD 505 DUTCHMANS LA EASTON, MD 21601 | | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 23 1997 | | 32. Registrar's Signature Julia Davidson-Randall | | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38676

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

CHARLOTTE

COHEN

2. Date of Death

DEC.

Day

Year

3. Time of Death

1 PM

4a. Facility Name (If not institution, give street and number)

6807 FAIRLAWN AVENUE

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

5. Social Security Number

216-16-1880

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

74 Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

May 21, 1923

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

6807 FAIRLAWN AVENUE

10f. Zip Code

21215

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: WHITE

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

2

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

SECRETARY

16b. Kind of Business/Industry

AFL-CIO
MD AND WASHINGTON

17. Father's Name (First, Middle, Last)

HYMAN

COHEN

18. Mother's Name (First, Middle, Maiden Surname)

ANNA

KAPLAN

19a. Informant's Name/Relationship (Type, Print)

LEONARD COHEN/ BROTHER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4 TROTTERS CT; #201; BALTIMORE, MD 21208

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

HEBREW YOUNG MEN

Date

12-21-97

20c. Location - City or Town, State

BALTIMORE, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

SOL LEVINSON & BROS., INC.

8900 REISTERSTOWN RD., PIKESVILLE, MD 21208

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Colon cancer with lung metastases

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

9 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D37144

29d. Date signed (Month, Day, Year)

12/19/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Susan Molinaro, MD 10755 Falls Rd, Suite 200, Lutherville, MD 21093

31. Date filed (Month, Day, Year)

DEC 23 1997

32. Registrar's Signature

John Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permitted. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

CHRISTIAN NEAL CUMOR Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

B.K.S

State of Maryland / Department of Health and Mental Hygiene

97-7326-005 Items: 23 part I, 27, 28a-f per MEO G-755 1/5/96 Certificate of Death

Reg. No.

97 38677

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. If item 27 is marked other than "natural" or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | | | | | |
|--|--|---|--|--|--|--|--|---|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) CHRISTIAN NEAL CUMOR | | | | 2. Date of Death Month Day Year DEC. 19, 1997 | | 3. Time of Death 12:20 PM | |
| | 4a. Facility Name (If not institution, give street and number) 1507 EAST JOPPA ROAD- TOWSON EAST MOTEL | | | | 4b. City, Town, or Location of Death TOWSON | | 4c. County of Death BALTIMORE | |
| Funeral Director | 5. Social Security Number 216-15-8608 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (in yrs. last birthday) 25 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) 3/21/72 | 9. Birthplace (State or Foreign Country) MARYLAND |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State MD | | 10b. County BALTIMORE | | 10c. City, Town or Location PARKVILLE | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10e. Street and Number 1833 CLEARWOOD ROAD | | | | 10f. Zip Code 21234 | | 10g. Citizen of What Country? USA | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th GRADE | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) SURVEYOR | | | 16b. Kind of Business/Industry SURVEYING CO. | |
| 17. Father's Name (First, Middle, Last) JOHN E. CUMOR | | | | 18. Mother's Name (First, Middle, Maiden Surname) MARLENE Y. JETT | | | | |
| 19a. Informant's Name/Relationship (Type, Print) JOHN E. CUMOR FATHER | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1833 CLEARWOOD ROAD BALTIMORE, MD 21234 | | | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) METRO CREMATORY, INC. | | Date 12/24/97 | | 20c. Location - City or Town, State CATONSVILLE, MD |
| 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility JOHNSON FUNERAL HOME 8521 LOCH RAVEN BLVD. TOWSON, MD 21286 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. NARCOTIC AND ALCOHOL INTOXICATION Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | | | | | | | Approximate Interval Between Onset and Death |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | |
| | | | | | | | 24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) MOTEL | | | | |
| 27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day, Year) found 12/19/97 | | 28b. Time of Injury found 1:00 | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| | | | | 28d. Describe how injury occurred Unknown | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) 1507 Joppa Rd. #118 Baltimore Co., Md. | | |
| 29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. Signature and title of certifier | | 29c. License number O.C.M.E | | 29d. Date signed (Month, Day, Year) DEC. 20, 1997 |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ann Dixon, M.D. 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 23 1997 | | | | 32. Registrar's Signature | | | | |

Handwritten signature

DEC 2 1931

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38678

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Clementine N. Dennison

2. Date of Death

December 19, 1997

3. Time of Death

2:15 AM

4a. Facility Name (If not institution, give street and number)

Stella Maris Hospice at Mercy

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

n/a

Funeral
Director

5. Social Security Number

506 10 7471

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

81 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

July 10, 1916

9. Birthplace (State or Foreign Country)

Kansas

Usual Residence of Decedent

10a. State

Maryland

10b. County

n/a

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2602 Miles Ave.

10f. Zip Code

21211

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married

3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (13-16)

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Book Keeper

16b. Kind of Business/Industry

Maryland State Gov't.

17. Father's Name (First, Middle, Last)

Ed Nutter

18. Mother's Name (First, Middle, Maiden Summa)

Della Martin

19a. Informant's Name/Relationship (Type, Print)

David Oden / Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2602 Miles Ave., Baltimore, MD 21211

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Green Mount Crematory 12/20/97

Date

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Location

Stephen D. Lohrmann

22. Name and Address of Facility

CAFA Stephen D. Lohrmann P.A.
8717 Green Pastures Dr., Baltimore, MD 21286

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Renal Failure

Due to (or as a consequence of):

b. End Stage Liver Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 mo

years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) STELLA MARIS AT MERCY HOSPICE

27. Manner of Death

1 ☒ Natural

2 ☐ Accident

3 ☐ Suicide

4 ☐ Homicide

5 ☐ Pending Investigation

6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Michael Cox

29c. License number

021561

29d. Date signed (Month, Day, Year)

12/19/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Michael Cox, M.D. 301 ST. PAUL PLACE STE 718 Baltimore, MD 21202

31. Date filed (Month, Day, Year)

DEC 23 1997

32. Registrar's Signature

Julia Davidson-Randall

State
Registrar

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

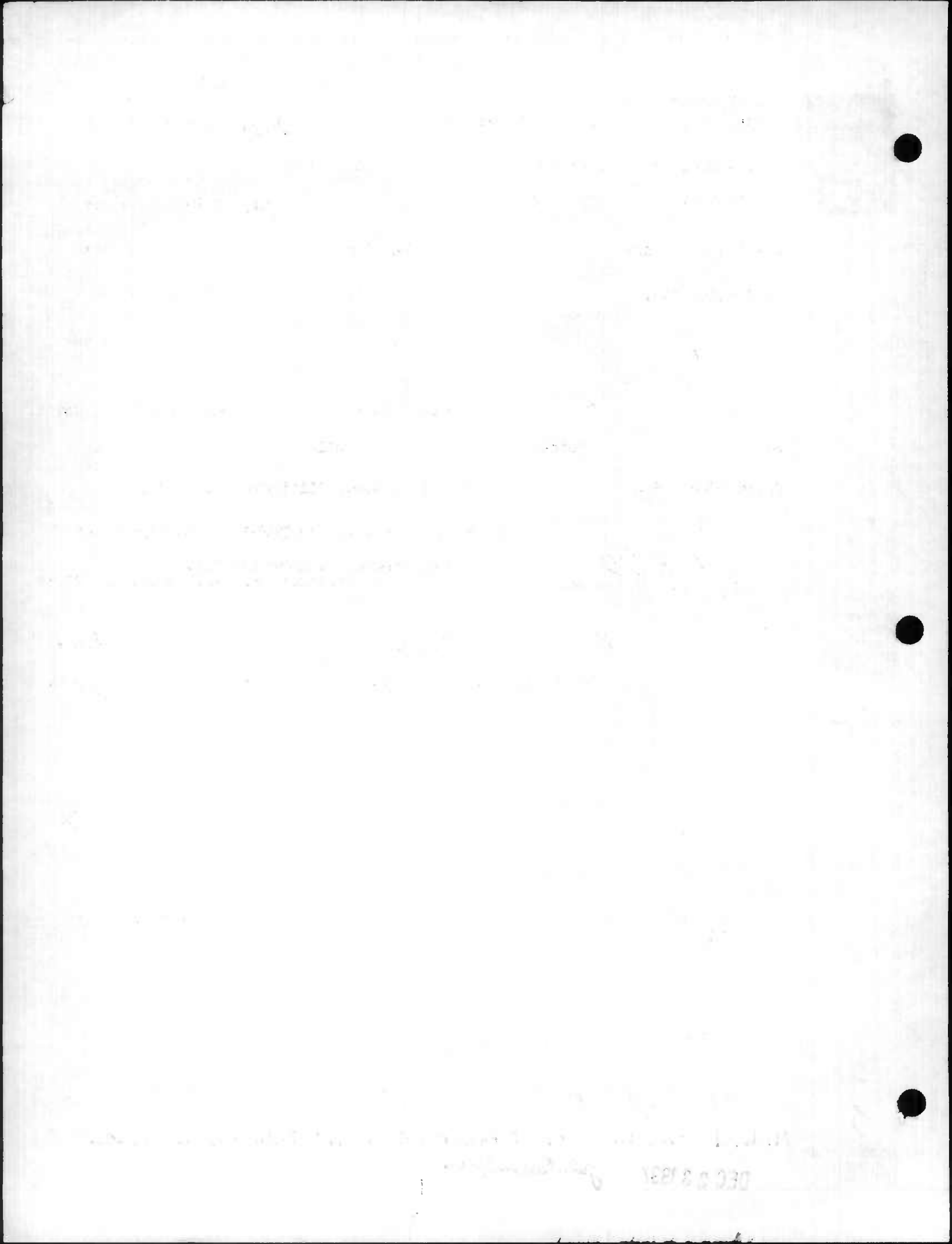
CLEMENTINE DENNISON

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be completed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.



Original Document

DEC 2 1931

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 38679

Certificate of Death

Reg. No.

| | | | | | | | | | |
|---|--|--|---------------------------------|--|---|--|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) <u>William Mark Dunsmore</u> | | | | 2. Date of Death Month <u>December</u> Day <u>20</u> , Year <u>1997</u> | | 3. Time of Death <u>5:22 am</u> | | |
| | 4a. Facility Name (If not institution, give street and number) <u>Franklin Square Hospital Center</u> | | | | 4b. City, Town, or Location of Death <u>Rosedale</u> | | 4c. County of Death <u>Baltimore</u> | | |
| Funeral Director | 5. Social Security Number <u>220-78-9461</u> | | 6. Sex <u>1</u> M <u>2</u> F | | 7. Age (In yrs. last birthday) <u>34</u> Yrs. | | 8. Date of Birth (Month, Day, Year) <u>July 23, 1963</u> | | |
| | 9. Birthplace (State or Foreign Country) <u>Maryland</u> | | 10a. State <u>Md.</u> | | 10b. County <u>Baltimore</u> | | 10c. City, Town or Location <u>Middle River</u> | | |
| To Be Completed by Funeral Director | Usual Residence of Decedent 10a. State <u>Md.</u> 10b. County <u>Baltimore</u> 10c. City, Town or Location <u>Middle River</u> | | | | 10d. Inside City Limits <u>1</u> Yes <u>2</u> No | | 10e. Street and Number <u>22 Selfridge Road</u> | | |
| | 10f. Zip Code <u>21220</u> | | | | 10g. Citizen of What Country? <u>USA</u> | | 11. Marital Status <u>1</u> Never Married <u>2</u> Married <u>3</u> Widowed <u>4</u> Divorced | | |
| To Be Completed by Physician/Medical Examiner | 12. Was Decedent Ever in U.S. Armed Forces? <u>1</u> Yes <u>2</u> No If Yes, Give Year or Dates: | | | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <u>1</u> Yes <u>2</u> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: <u>White</u> | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>1yr</u> College (1-4 or 5+) <u>1yr</u> | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>Restaurant Worker</u> | | 16b. Kind of Business/Industry <u>Food</u> | | |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last) <u>Charles Dunsmore</u> | | | | 18. Mother's Name (First, Middle, Maiden Surname) <u>Shirley Swain</u> | | | | |
| | 19a. Informant's Name/Relationship (Type, Print) <u>Shirley Dunsmore/mother</u> | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>22 Selfridge Road Baltimore Md. 21220</u> | | | | |
| To Be Completed by Physician/Medical Examiner | 20a. Method of Disposition <u>1</u> Burial <u>2</u> Cremation <u>3</u> Removal from State <u>4</u> Donation <u>5</u> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) <u>Metro Crematory Inc.</u> | | 20c. Location - City or Town, State <u>Baltimore Md.</u> | | |
| | 21. Signature of Funeral Service Licensee <u>R. Terry Connelly</u> | | | | 22. Name and Address of Facility <u>Connelly Funeral Home of Essex</u> <u>300 Mace Ave. Baltimore Md. 21221</u> | | | | |
| To Be Completed by Physician/Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death, shock, or heart failure. List <u>one</u> cause on each line. <u>a. Pneumocystis Carinii Pneumonia</u> Due to (or as a consequence of): <u>b. Human Immunodeficiency Virus</u> Due to (or as a consequence of): <u>c.</u> Due to (or as a consequence of): <u>d.</u> | | | | 23b. Did tobacco use contribute to the cause of death? <u>1</u> Yes <u>2</u> No <u>3</u> Probably <u>4</u> Unknown | | Approximate Interval Between Onset and Death <u>15 days</u> <u>4 years</u> | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 24a. Was an autopsy performed? <u>1</u> Yes <u>2</u> No | | 24b. Were autopsy findings available prior to completion of cause of death? <u>1</u> Yes <u>2</u> No | | |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner? <u>1</u> Yes <u>2</u> No | | | | 26. Place of Death (Check only one) Hospital: <u>1</u> Inpatient <u>2</u> ER/Outpatient <u>3</u> OOA Other: <u>4</u> Nursing Home <u>5</u> Residence <u>6</u> Other (Specify) | | | | |
| | 27. Manner of Death <u>1</u> Natural <u>5</u> Pending investigation <u>2</u> Accident <u>6</u> Could not be determined <u>3</u> Suicide <u>4</u> Homicide | | | | 28a. Date of injury (Month, Day, Year) <u>12/20/97</u> | | 28b. Time of injury <u>M</u> | | |
| To Be Completed by Physician/Medical Examiner | 28c. Injury at Work? <u>1</u> Yes <u>2</u> No | | | | 28d. Describe how injury occurred | | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) | | |
| | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. Certifier (Check only one) <u>1</u> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <u>2</u> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | |
| To Be Completed by Physician/Medical Examiner | 29b. Signature and title of certifier <u>Gerri Davis MD</u> | | | | 29c. License number <u>RD-1982</u> | | 29d. Date signed (Month, Day, Year) <u>12/20/97</u> | | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>Gerri Davis M.D. 9000 Franklin Square Drive Baltimore Maryland 21237</u> | | | | 31. Date filed (Month, Day, Year) <u>DEC 23 1997</u> | | | | |
| 32. Registrar's Signature <u>Judy Davidson-Randall</u> | | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

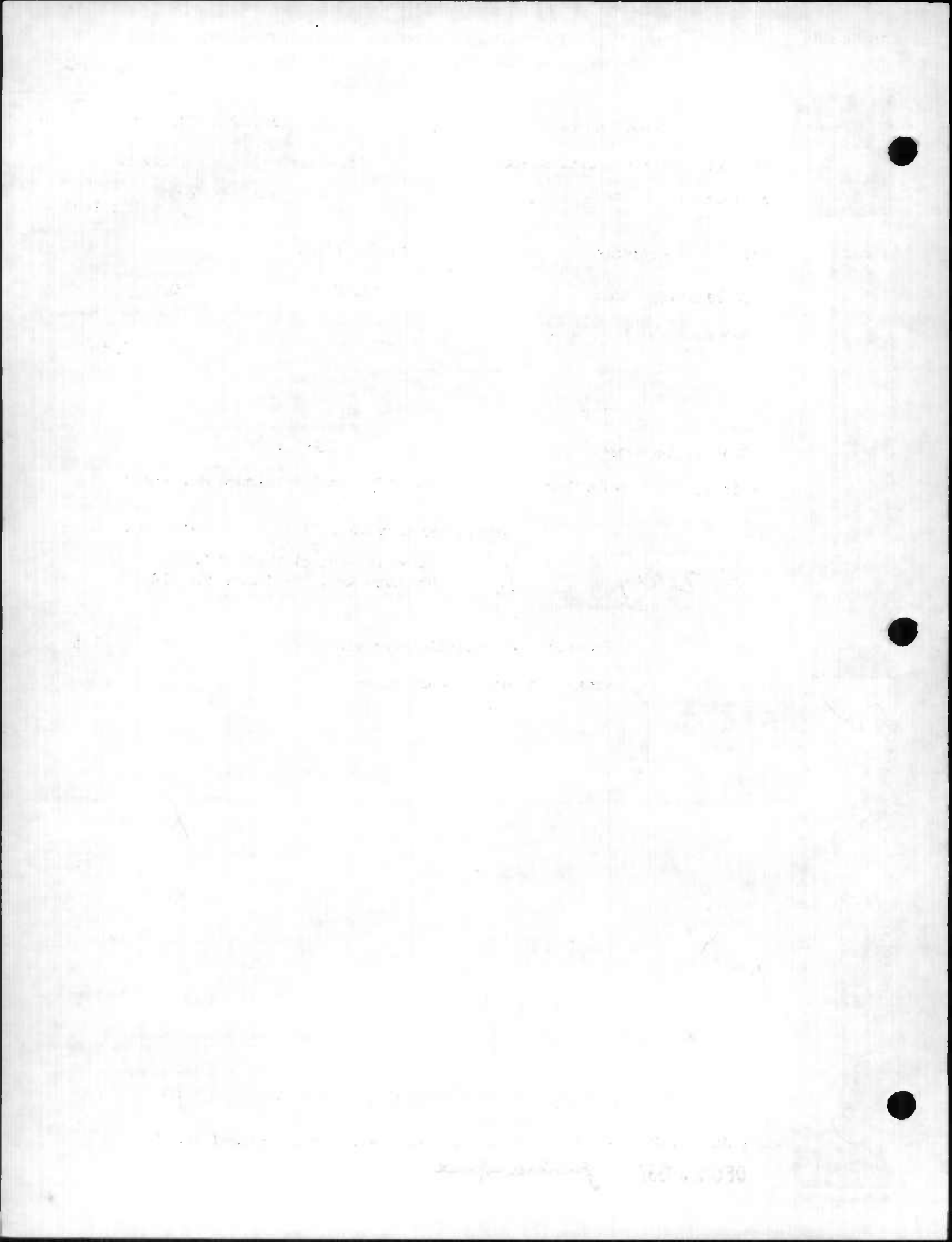
Division of Vital Records, P.O. Box 66760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit.

3

State
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38680

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Ralph Edward

DAPKUS

2. Date of Death

Month Day Year
December 20, 1997

3. Time of Death

5:19 PM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Franklin Square Hospital Center

4b. City, Town, or Location of Death

Rosedale

4c. County of Death

Baltimore

5. Social Security Number

214-38-4788

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

56

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
June 28, 1941

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore County

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

1-H Maidstone Court

10f. Zip Code

21237

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☐ Married☐ Widowed ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

☒ Yes ☐ No

If Yes, Give

Year or Dates: 1962-

1968

13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify:

White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

10th Grade

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Military

16b. Kind of Business/Industry

United States
Government

17. Father's Name (First, Middle, Last)

Edward Louis Dapkus

18. Mother's Name (First, Middle, Maiden Surname)

Emma Lilly Pickering

19a. Informant's Name/Relationship (Type, Print)

Emma L. Wachlin/Mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1-H Maidstone Court, Baltimore, Maryland 21237

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Gardens of Faith Cemetery

Date

12/23/97

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

John C. Miller, Inc.
6415 Belair Road, Baltimore, Maryland 2120623a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Atherosclerotic Heart Disease

15 Years

Due to (or as a consequence of):

b. Diabetes

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☒ Yes ☐ No ☐ Probably ☐ Unknown24a. Was an autopsy
performed?☐ Yes ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?☐ Yes ☐ No25. Was case referred to medical
examiner?☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital: ☐ Inpatient ☒ Outpatient☐ DOAOther: ☐ Nursing Home☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Accident☐ Suicide☐ Homicide☐ Pending Investigation☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☐ No28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

AV2740303

29d. Date signed (Month, Day, Year)

12/29/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ross Van Antwerp MD. 9000 Franklin Square Dr. Balto, Md. 21237

31. Date filed (Month, Day, Year)

DEC 23 1997

32. Registrar's Signature

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filled within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural," or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be completed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38681

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Lillian S. Engelhardt

2. Date of Death

Month Day Year
DECEMBER 18 1997 12:49 pm

3. Time of Death

Funeral
Director

4a. Facility Name (If not institution, give street and number)

GREATER BALTIMORE MEDICAL CENTER

4b. City, Town, or Location of Death

TOWSON

4c. County of Death

BALTIMORE

5. Social Security Number

219 12 7845

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

79 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
July 31 1918

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Parkville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1609 Orlando Rd.

10f. Zip Code

21234

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

9

College (1-4 or 5+)

18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

Home

17. Father's Name (First, Middle, Last)

Albert Biddison

18. Mother's Name (First, Middle, Maiden Surname)

Lillian Swift

19a. Informant's Name/Relationship (Type, Print)

Judy Small

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1609 Orlando Rd. Parkville Maryland 21234

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Parkwood Cemetery

Date

December 22 1997

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

EVANS Chapel of Memories
8800 Hartford Rd Baltimore MD. 21234

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Hemorrhage in brain due to thrombosis

Due to (or as a consequence of):

b. acute ischemic cardiac syndrome

Due to (or as a consequence of):

c. coronary atherosclerosis

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

COPD emphysema

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of injury (Month, Day, Year)

28b. Time of injury

M

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

[Signature]

29c. License number

#18792

29d. Date signed (Month, Day, Year)

12/18/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

J. R. B. D. O. F. A. C. C.

6565 N. Charles St Suite 615 Baltimore 21204

31. Date filed (Month, Day, Year)

DEC 23 1997

32. Registrar

[Signature]

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38682

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

John Howard Edwards III

2. Date of Death

December

Day

15

Year

1997

3. Time of Death

1:00 pm

4a. Facility Name (If not institution, give street and number)

5323 Hydes Rd.

4b. City, Town, or Location of Death

Hydes

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

217 90 8493

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

27 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

July 19 1970

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Hydes

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

5323 Hydes Rd.

10f. Zip Code

21082

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No.
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Student

16b. Kind of Business/Industry

Education

17. Father's Name (First, Middle, Last)

John Howard Edwards Jr.

18. Mother's Name (First, Middle, Maiden Surname)

Moira Martin

19a. Informant's Name/Relationship (Type, Print)

John H. Edwards Jr.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5323 Hydes Rd. Hydes Maryland 21082

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Greenmount Crematory

Date

December
16 1997

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

EVANS Chapel of Memories
8800 Harford Rd. Baltimore MD. 2123423a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)a. Self-inflicted gunshot wound of head
Due to (or as a consequence of):Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic depression

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☒ Suicide 4 ☐ Homicide
5 ☐ Pending investigation
6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)
DEC 15, 1997

28b. Time of Injury

1300 M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

Self-inflicted

28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)

HOME

28f. Location (Street and Number or Rural Route Number,
City or Town, State)

5323 HYDES RD. HYDES MD

29a. Certifier
(Check only
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

J. Crossan O'Donovan, M.D.

29c. License number

D07632

29d. Date signed (Month, Day, Year)

DEC 17 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Crossan O'Donovan M.D. 2112 Dundalk Ave

BALTO MD 21222

31. Date filed (Month, Day, Year)

DEC 23 1997

32. Registrar's Signature

[Signature]

State
Registrar

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38683

| | | | | | | | | | | |
|--|---|---------------------------------|---|--|--|--|--|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) JOANNE MARIE ERWIN | | | | | | 2. Date of Death Month Dec Day 18th Year 1997 | | 3. Time of Death 3:50 pm | |
| | 4a. Facility Name (If not institution, give street and number) LEVINDALE NURSING CENTER | | | | | | 4b. City, Town, or Location of Death BALTIMORE | | 4c. County of Death N/A | |
| Funeral Director | 5. Social Security Number 218-48-0683 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 48 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) 4/2/49 | | 9. Birthplace (State or Foreign Country) MARYLAND | |
| | Usual Residence of Decedent | | | | | | | | | |
| 10a. State MD | | 10b. County N/A | | 10c. City, Town or Location BALTIMORE | | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 10e. Street and Number 2115 BOLTON STREET | | | | 10f. Zip Code 21217 | | 10g. Citizen of What Country? U.S. | | | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: BLACK | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) -0- | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) TAX EXAMINER | | | 16b. Kind of Business/Industry STATE | | | |
| 17. Father's Name (First, Middle, Last) MOSES EVANS | | | | | | 18. Mother's Name (First, Middle, Maiden Surname) JOAN JOHNSON | | | | |
| 19a. Informant's Name/Relationship (Type, Print) LaVONNE MADDEN (SISTER) | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2115 BOLTON STREET-BALTO., MD 21217 | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) NEW CATHEDRAL CEMETERY | | Date 12/23/97 | | 20c. Location - City or Town, State BALTIMORE | | |
| 21. Signature of Funeral Service Licensee | | | | | | 22. Name and Address of Facility 1721-27 N. MONROE ST. ELIZABETH L. PHILLIPS-BALTO., MD 21217 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. acute cardio-pulmonary arrest Due to (or as a consequence of): b. Coronary artery disease Due to (or as a consequence of): c. respiratory insufficiency Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Myocardial infarction, aortic aneurysm, Hypertension, recent Aspiration Pneumonia, Seizure, Congestive heart failure | | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | |
| 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | 27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | | | |
| 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how Injury occurred | | | | |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | 29b. Signature and title of certifier | | | | |
| 29c. License number D-44907 | | | | | | 29d. Date signed (Month, Day, Year) Dec 18th 1997 | | | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) 2434 W. Belvidere Ave Baltimore, MD 21215 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 23 1997 | | | | | | 32. Registrar's Signature | | | | |

Baltimore, Maryland 21215-0020

Permits: Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

Erwin, Joann

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38684

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

JOSHUA S. EATON

2. Date of Death

Month Day Year
December 22, 19973. Time of Death
4:10 A.M.

4a. Facility Name (If not institution, give street and number)

Fairhaven

4b. City, Town, or Location of Death

Sykesville

4c. County of Death

Carroll

Funeral
Director

5. Social Security Number

705-10-5116

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

93

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Nov 19, 1904

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence

10a. State

Maryland

10b. County

Carroll

10c. City, Town or Location

Sykesville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7200 Third Avenue Apt. 205 B

10f. Zip Code

21784

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - if Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12 Years

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Purchasing Agent

16b. Kind of Business/Industry

Western MD Railway

17. Father's Name (First, Middle, Last)

John Conrad Eaton

18. Mother's Name (First, Middle, Maiden Surname)

Martha Jane Stuller

19a. Informant's Name/Relationship (Type, Print)

Mr. John C. Eaton

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7432 John Pickett Road Woodbine, MD 21797

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Meadow Branch Cemetery

Date

12/27

20c. Location - City or Town, State

Westminster, Maryland

21. Signature of Funeral Service Licensee

Stephen M. Joubert

22. Name and Address of Facility

Loring Byers Funeral Directors, Inc.

8728 Liberty Road Randallstown, MD 21133

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Dehydration

Due to (or as a consequence of):

10 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Dysphagia

Due to (or as a consequence of):

3 months

c. Cerebrovascular accident

Due to (or as a consequence of):

3 months

d. Cerebrovascular disease

Due to (or as a consequence of):

5 years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

William Tan MD

29c. License number

D34849

29d. Date signed (Month, Day, Year)

December 22 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

William Tan MD 1645 Liberty Road Ekersburg MD 21784

31. Date filed (Month, Day, Year)

DEC 23 1997

32. Registrar's Signature

John Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

JAMES M. FLAGG

Items: 23 part I, 27, 28a-f per MEO G-755 1/2/97 ^{rab} Certificate of Death

Reg. No.

97 38685

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

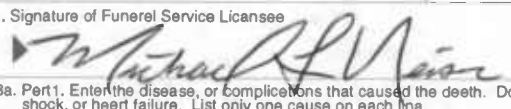

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Physician
/Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | | |
|---|--|---|--|--|---|
| 1. Decedent's Name (First, Middle, Last) James Flagg | | 2. Date of Death Month Day Year DEC. 8, 1997 | | 3. Time of Death 1408 PM | |
| 4a. Facility Name (If not institution, give street and number) 6040 EAST PRATT STREET | | | 4b. City, Town, or Location of Death BALTIMORE | | 4c. County of Death N/A |
| 5. Social Security Number 220-68-0828 | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 42 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) Nov. 25, 1955 |
| 9. Birthplace (State or Foreign Country) Balto., Md. | | | | | |
| 10a. State Md. | | 10b. County Baltimore | | 10c. City, Town or Location Baltimore | |
| 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| 10e. Street and Number 6040 Pratt Street | | | 10f. Zip Code 21224 | | 10g. Citizen of What Country? U.S.A. |
| 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | |
| 14. Race - American Indian, Black, White, etc. Specify: White | | | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10th Collage (1-4 or 5+) Collage | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Electrician | | 16b. Kind of Business/Industry Electrical | |
| 17. Father's Name (First, Middle, Last) Robert Flagg, Sr. | | | 18. Mother's Name (First, Middle, Maiden Surname) Nancy Brilhart | | |
| 19a. Informant's Name/Relationship (Type, Print) Robert Flagg/Brother | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2860 Plainfield Rd., Balto., Md. 21222 | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Baltimore-Washington crematory | | 20c. Location - City or Town, State Laurel, Md. | |
| 21. Signature of Funeral Service Licensee  | | 22. Name and Address of Facility Bradley-Ashton-Dabrowski-Matthews Funeral Home, Inc. 2134 Willow Spring Rd., Balto., Md. 21222 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. NARCOTIC INTOXICATION Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | | | | |
| 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | |
| 24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) found 12/8/97 | | 28b. Time of Injury 2:08 PM | |
| 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred Unknown | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Found: Residence | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6040 E. Pratt St. Baltimore, Md. | | | |
| 29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | |
| 29b. Signature and title of certifier  | | 29c. License number O.C.M.E | | 29d. Date signed (Month, Day, Year) DEC. 9, 1997 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARYDAVIDSON K. KORSU 111 Penn Street, Baltimore, Maryland 21201 | | | | | |
| 31. Date filed (Month, Day, Year) DEC 23 1997 | | 32. Registrar's Signature  | | | |

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38686

Ethel Foster

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician / Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | | |
|---|--|---|--------------------------------|--|--|
| 1. Decedent's Name (First, Middle, Last) ETHEL ELIZABETH FOSTER | | 2. Date of Death Month Day Year DECEMBER 20 1997 | | 3. Time of Death 10:50 am | |
| 4a. Facility Name (If not institution, give street and number) GREATER BALTIMORE MEDICAL CENTER | | 4b. City, Town, or Location of Death TOWSON | | 4c. County of Death BALTIMORE | |
| 5. Social Security Number 218-28-1589 | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 64 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) JUNE 1, 1933 |
| 9. Birthplace (State or Foreign Country) MARYLAND | | | | | |
| 10a. State MARYLAND | | 10b. County HARFORD | | 10c. City, Town or Location Pylesville | |
| 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 10e. Street and Number 1703 SCOTT ROAD | | 10f. Zip Code 21132 | | 10g. Citizen of What Country? U.S.A. | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 YRS. College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) WAITRESS | | 16b. Kind of Business/Industry RESTAURANT | |
| 17. Father's Name (First, Middle, Last) EDWARD CHARLES VOLLROT | | 18. Mother's Name (First, Middle, Maiden Surname) ETHEL ELIZABETH PAROKE | | | |
| 19a. Informant's Name/Relationship (Type, Print) OSBORAH R. WITHERITE | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1703 SCOTT ROAD PYLESVILLE, MARYLAND 21132 | | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) GREEN MOUNT CREMATORY | | 20c. Location - City or Town, State BALTIMORE, MARYLAND | |
| 21. Signature of Funeral Service Licensee <i>[Signature]</i> | | 22. Name and Address of Facility EVANS FUNERAL CHAPEL - BELAIR, P.A. 21050 3 NEWPORT DRIVE FOREST HILL, MARYLAND | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. BREAST CANCER, METASTATIC Due to (or as a consequence of): Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | | | | Approximate Interval Between Onset and Death 2 YR |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| | | | | | 24e. Were en autops performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | |
| | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | |
| 29b. Signature and title of certifier D. S. I. C. M.D. | | 29c. License number D27730 | | 29d. Date signed (Month, Day, Year) 12/21/97 | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) GARY COHEN, MD 6569 N. CHARLES ST. BALTIMORE, MD 21204 | | | | | |
| 31. Date filed (Month, Day, Year) DEC 23 1997 | | 32. Registrar's Signature <i>[Signature]</i> | | | |

THE [illegible] OF [illegible]

BY [illegible]

IN [illegible]

AND [illegible]

OF [illegible]

THE [illegible]

OF [illegible]

THE [illegible]

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THE [illegible]

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Dorothy Evelyn Fried

2. Date of Death

Month Day Year
December 19 1997

3. Time of Death

10:45 PM

4a. Facility Name (If not institution, give street and number)

Mariner Health of Forest Hill

4b. City, Town, or Location of Death

Forest Hill

4c. County of Death

Harford

Funeral
Director

5. Social Security Number

215-18-0736

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

74

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Jan. 31-1923

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Harford

10c. City, Town or Location

Bel Air

10d. Inside City Limits

1 ☐ Yes 2 ☐ No

10e. Street and Number

1200 Midwood Ct.

10f. Zip Code

21014

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

8 yrs

College (1-4or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

John Clark

18. Mother's Name (First, Middle, Maiden Surname)

Anna Raguckas

19a. Informant's Name/Relationship (Type, Print)

Linda A. Vitali - Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1200 Midwood Ct. Bel Air, Md. 21014

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Holy Cross Cemetery

Date

12-22

20c. Location - City or Town, State

Brooklyn, Md.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Schimunek Funeral Home of Bel Air, Inc.

610 W. MacPhail Rd. Bel Air, Md. 21014

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Chronic renal failure

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

028339

29d. Date signed (Month, Day, Year)

December 20, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Linda A. Vitali 101 E Wheel Road Bel Air MD 21011

31. Date filed (Month, Day, Year)

DEC 23 1997

32. Registrar's Signature

Julia Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Items: 7,8 Per FH Film G-754 12-31-97R State of Maryland / Department of Health and Mental Hygiene 97 38688

Item#23a Part1b per MEO G754 12/23/97 EW

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|---|---|---|--|--|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Edward R. Fuller | | | | 2. Date of Death Month Dec Day 16 Year 1997 | | 3. Time of Death 19:45 | |
| | 4a. Facility Name (If not institution, give street and number) Anne Arundel Medical Center | | | | 4b. City, Town, or Location of Death Annapolis | | 4c. County of Death Anne Arundel | |
| Funeral Director | 5. Social Security Number 223-18-0115A | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 82 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) 5-17-15 | 9. Birthplace (State or Foreign Country) MASSACHUSETTS |
| | Usual Residence of Decedent | | | | | | | |
| To Be Completed by Funeral Director | 10a. State Maryland | 10b. County Anne Arundel | 10c. City, Town or Location Annapolis | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | 10e. Street and Number 31 Heritage Court | | | 10f. Zip Code 21401 | | 10g. Citizen of What Country? USA | | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: BLACK | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Merchant Seaman | | 16b. Kind of Business/Industry UKN | | | |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last) UKN | | | | 18. Mother's Name (First, Middle, Maiden Surname) UKN | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Ronald Hoff (son) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3716 MARMON AVE. BALTO, MD. 21207 | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) CROWN VILLE MD. VETERAN CEMETERY | | Date 12/23/97 | | 20c. Location - City or Town, State CROWN VILLE, MD. | |
| | 21. Signature of Funeral Service Licensee Jeff Miller | | 22. Name and Address of Facility House of Dicks F/H 1922 Forest Drive Annapolis, Md. | | | | | |
| Physician /Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Acute Renal failure | | | | | | | Approximate Interval Between Onset and Death |
| | Due to (or as a consequence of): Septicemia | | | | | | | |
| | Due to (or as a consequence of): | | | | | | | |
| | Due to (or as a consequence of): | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1. Septicemia 2. Double pneumonia 3. Severe Dementia 4. Myocardial infarction 5. Multiple decubiti 6. Anemia | | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| 29b. Signature and title of certifier Edward R. Fuller | | | | 29c. License number 009453 | | 29d. Date signed (Month, Day, Year) 12/17/97 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Forest Phillip 1833 A. Forest Dr Annapolis Md. 21401 | | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 23 1997 | | 32. Registrar Julia Davidson | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

37 38689

| | | | | | | | | | | |
|--|--|--|---|--|--|--|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) George Frederick Jr. | | | | | | 2. Date of Death Month December Day 7 Year 1997 | | 3. Time of Death 1:20 a.m. | |
| | 4a. Facility Name (If not institution, give street and number) Augsburg Lutheran Village | | | | | | 4b. City, Town, or Location of Death Baltimore | | 4c. County of Death | |
| Funeral Director | 5. Social Security Number 215-01-7712 | | 8. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 87 Yrs. | | If Under 1 Year Months Days | | If Under 24 Hrs. Hours Min. | |
| | 9. Birthplace (State or Foreign Country) Maryland | | 8. Date of Birth (Month, Day, Year) Aug. 24, 1910 | | 10a. State Maryland | | 10b. County Baltimore | | 10c. City, Town or Location Baltimore | |
| Usual Residence of Decedent | | | | | | | | | | |
| 10a. State Maryland | | | 10b. County Baltimore | | | 10c. City, Town or Location Baltimore | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10e. Street and Number 6811 Campfield Road | | | 10f. Zip Code 21217 | | | 10g. Citizen of What Country? U.S.A. | | | | |
| 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: white | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0 | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Civil Service Printer | | | 16b. Kind of Business/Industry Federal Government | | | | |
| 17. Father's Name (First, Middle, Last) George Frederick Sr. | | | | | | 18. Mother's Name (First, Middle, Maiden Surname) Louise Kurtz | | | | |
| 19a. Informant's Name/Relationship (Type, Print) William G. Frederick/nephew | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1735 Army Navy Drive, Arlington, VA 22202 | | | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Date | | | 20c. Location - City or Town, State | | | | |
| 21. Signature of Funeral Service Licensee Ronald S. Wade Director | | | | | | 22. Name and Address of Facility State Anatomy Board, 655 W. Baltimore Street Baltimore, MD 21201 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>cardiomyopathy</u> Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ | | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. A. Fib. | | | | | | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how Injury occurred | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | 29b. Signature and title of certifier [Signature] | | | 29c. License number D 37573 | | | 29d. Date signed (Month, Day, Year) Dec. 12, 1997 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jef Zibell MD 7220 Park Heights Ave Baltimore MD 21208 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 23 1997 | | | 32. Registrar's Signature [Signature] | | | | | | | |

To Be Completed by Funeral Director

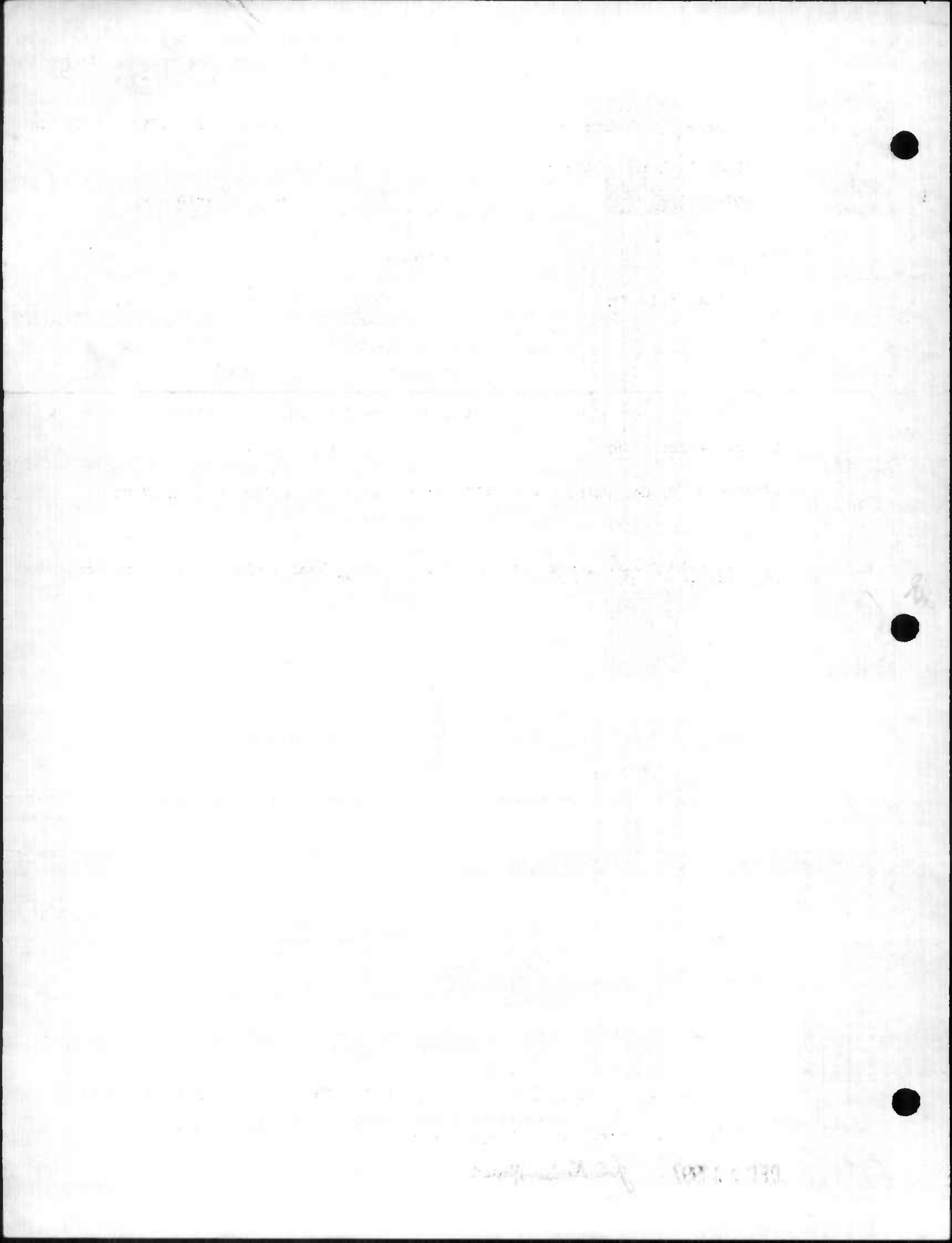
Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permits. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38690

Item: 7 per FH G-755 1/16/98 dh

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

HILDA MARY FITZ-ROY

2. Date of Death

Month Day Year
December 20, 1997

3. Time of Death

10:54 AM

4a. Facility Name (If not institution, give street and number)

Fairhaven Nursing Home

4b. City, Town, or Location of Death

Sykesville

4c. County of Death

Carroll County

5. Social Security Number

214-40-5563

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

86 87 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

June 28, 1910

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Carroll County

10c. City, Town or Location

Sykesville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7200 Third Avenue G-12

10f. Zip Code

21784

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Head Of English Department Department of Education

16b. Kind of Business/Industry

Baltimore City

17. Father's Name (First, Middle, Last)

Martin H. Poetzsch

16. Mother's Name (First, Middle, Maiden Summa)

Rose M. Luebeck

19a. Informant's Name/Relationship (Type, Print)

Janis Roberts, Step-daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

229 Westmont Road Baltimore Maryland 21228

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Loudon Park

Date

12/23/97 Baltimore Maryland

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

Witzke Funeral Home, Inc.
1630 Edmondson Avenue, Catonsville, MD 21228

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Hypertrophic cardiomyopathy
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 year

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Arteriosclerotic cardiovascular disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

[Signature]

29c. License number

D22220

29d. Date signed (Month, Day, Year)

December 20, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

1645 Liberty Road Eldersburg, MD. 21784

31. Date filed (Month, Day, Year)

DEC 23 1997

32. Registrar's Signature

[Signature]

State Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

LEE

M

FELDSTEIN

2. Date of Death

Month

Day

Year

DECEMBER 19 1997

3. Time of Death

8:50 AM

4a. Facility Name (If not institution, give street and number)

SINAI HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

219-22-9691

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

71

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

OCT. 25, 1926

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD

10b. County

BALTIMORE

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

29 STONEHENGE CIR., #3

10f. Zip Code

21208

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

☒ Yes ☐ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: WHITE

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

SALESPERSON

16b. Kind of Business/Industry

COMPUTERS

17. Father's Name (First, Middle, Last)

JACOB

FELDSTEIN

18. Mother's Name (First, Middle, Maiden Surname)

ROSE

FOX

19a. Informant's Name/Relationship (Type, Print)

LOIS FELDSTEIN (WIFE)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

29 STONEHENGE CIR., #3 BALTO., MD 21208

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

BALTIMORE HEBREW

Date

12/21/97

20c. Location - City or Town, State

REISTERSTOWN, MD

21. Signature of Funeral Service Licensee

▶ Ellen S. Levinson

22. Name and Address of Facility

SOL LEVINSON & BROS., INC.

8900 REISTERSTOWN RD., PIKESVILLE, MD 21208

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

BRAIN OLIGODENDRIONOMA

Approximate Interval Between Onset and Death

7 YEARS

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

PARTIAL COMPLEX SEIZURES

HYPOTHYROIDISM

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☒ Inpatient☐ ER/Outpatient☐ DOA

Other:

26. Place of Death (Check only one)

☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Accident☐ Suicide☐ Homicide☐ Pending Investigation☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☒ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

▶ D. T. ... MD

29c. License number

AS 2402321DT9020

29d. Date signed (Month, Day, Year)

DECEMBER 19, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DRORY S. TENDLER, M.D., SINAI HOSPITAL, GREENSPRING AVENUE

31. Date filed (Month, Day, Year)

DEC 23 1997

Registrar's Signature

Julia Davidson-Randall

State
Registrar

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

LEE FELDSTEIN M.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the funeral-transit certificate.

6

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38692

GRAVES, GEORGE
 Baltimore, Maryland 21215-0020
 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 202-555-5000.

To Be Completed by Funeral Director

| | | | | | | | |
|---|--|---|--|--|--------------------------------|---|--|
| 1. Decedent's Name (First, Middle, Last) George Kenneth Graves | | | | 2. Date of Death Month DECEMBER Day 19 Year 1997 | | 3. Time of Death 2:10PM | |
| 4a. Facility Name (If not institution, give street and number) St. Elizabeth Nursing Home | | | | 4b. City, Town, or Location of Death Baltimore City | | 4c. County of Death N/A | |
| 5. Social Security Number 217-01-5425 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 87 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) July 29, 1910 | |
| 9. Birthplace (State or Foreign Country) Maryland | | | | | | | |
| Usual Residence of Decedent | | | | | | | |
| 10a. State Maryland | | 10b. County Baltimore | | 10c. City, Town or Location Catonsville | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 10e. Street and Number 1104 Lisa Dale Circle Apt. 2D | | | | 10f. Zip Code 21228 | | 10g. Citizen of What Country? U.S.A. | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 Years College (1-4or 5+) N/A | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Repair | | 16b. Kind of Business/Industry BGE | |
| 17. Father's Name (First, Middle, Last) Unknown | | | | 18. Mother's Name (First, Middle, Maiden Surname) Christine Little | | | |
| 19a. Informant's Name/Relationship (Type, Print) Mrs. Christina Graves - Wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1104 Lisa Dale Circle Apt. 2D Catonsville, MD 21228 | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Garrett Co. Memorial Gar. | | Date 12/23/97 | | 20c. Location - City or Town, State Oakland, Maryland | |
| 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility Sterling Ashton Funeral Home, Inc. 736 Edmondson Avenue Catonsville, MD 21228 | | | |

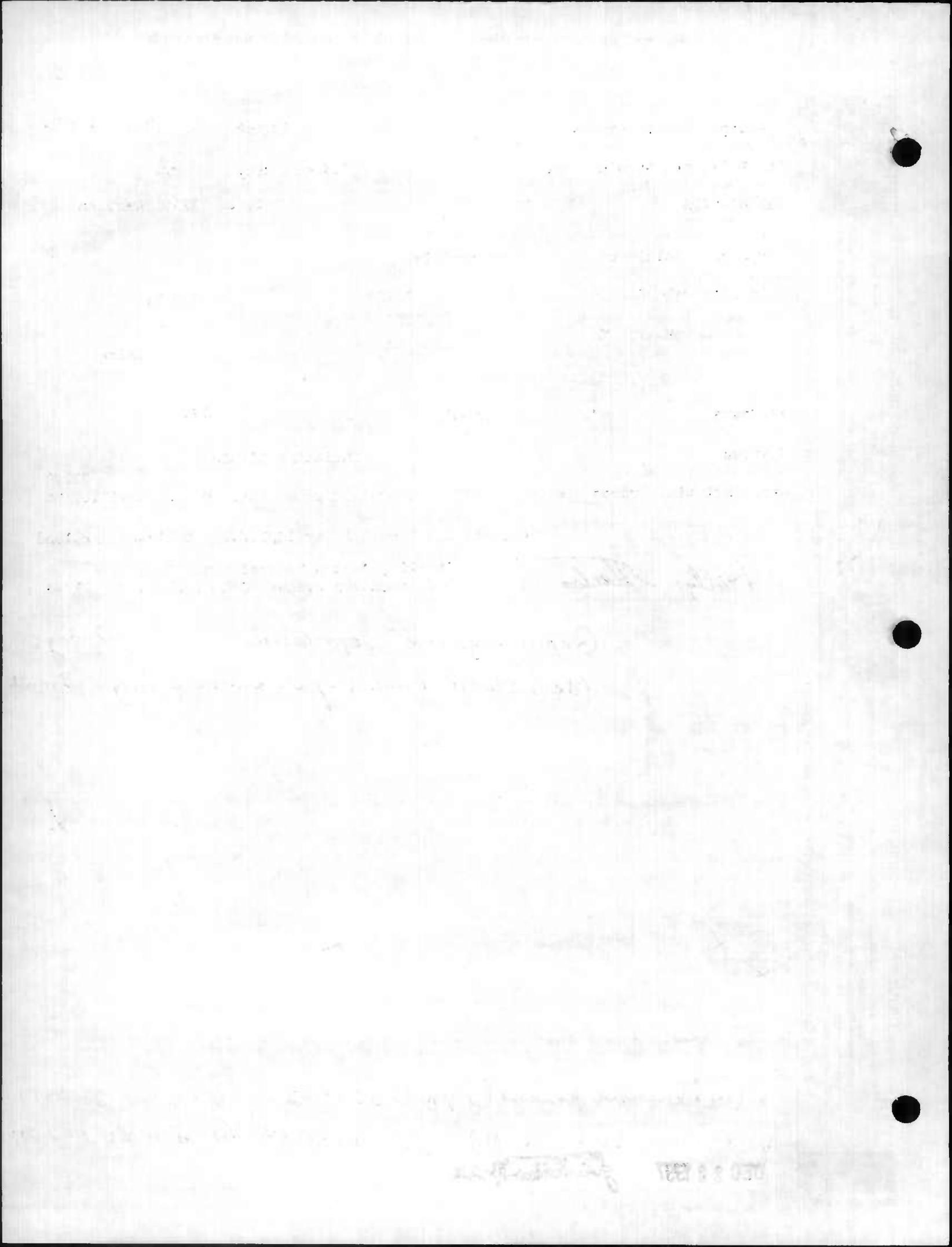
Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | | |
|--|--|---|--|---|--|
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Gram negative septicemia Due to (or as a consequence of): b. Metastatic cancer of unknown primary Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | | | Approximate Interval Between Onset and Death 2 days 3 months | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | |
| 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | 24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | 24d. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | |
| 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how Injury occurred | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | |
| 29b. Signature and title of certifier | | 29c. License number D30182 | | 29d. Date signed (Month, Day, Year) DECEMBER 21, 1997 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) William Russell MD 3320 Benson Ave Baltimore MD 21227 | | | | | |
| 31. Date filed (Month, Day, Year) DEC 23 1997 | | | | | |

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38693

Physician
/Medical
Examiner

Funeral
Director

1. Decedent's Name (First, Middle, Last)

Marjorie Garey

2. Date of Death

Month

Day

Year

12

10

97

3. Time of Death

10:45 AM

4a. Facility Name (If not institution, give street and number)

DePaul House, 3300 Benson Ave., Apt. 116

4b. City, Town, or Location of Death

Arbutus

4c. County of Death

Baltimore

5. Social Security Number

239-10-7878

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

79 Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Days

8. Date of Birth

(Month, Day, Year)

9. Birthplace (State or Foreign Country)

3/15/18

North Carolina

Usual Residence of Decedent

10a. State

Md.

10b. County

Baltimore

10c. City, Town or Location

Arbutus

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3300 Benson Ave., Apt. 116

10f. Zip Code

21227

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

11

College (14 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Zeff R. Lytton

18. Mother's Name (First, Middle, Maiden Surname)

Pearl Jean Deaton

19a. Informant's Name/Relationship (Type, Print)

Rebecca Stover - daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6428 Golden Oaks Drive, Linthicum, Md. 21090

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Cedar Hill Cemetery

Date

12/13/97

20c. Location - City or Town, State

Glen Burnie, Md.

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

Gary L. Kaufman Funeral Home at Meadowridge MP, Inc.
7250 Washington Blvd., Elkridge, Md. 21075

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. *Bladder Cancer*
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

Other:

4 ☐ Nursing Home

5 ☒ Residence

6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Fouad M. Abbas

29c. License number

D 38 972

29d. Date signed (Month, Day, Year)

12/11/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Fouad Abbas, MD, Harbor Hospital Cancer Center, Baltimore, Md.

31. Date filed (Month, Day, Year)

DEC 23 1997

32. Registrar's Signature

Julia Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit.

1870

2nd

1871

3rd

4th

5th

6th

7th

8th

9th

X

10th

11th

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38694

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

VINCENT EDWARD GREENAN

2. Date of Death

Month December Day 12 Year 97

3. Time of Death

1435

4a. Facility Name (If not institution, give street and number)

WASHINGTON COUNTY HOSPITAL

4b. City, Town, or Location of Death

HAGERSTOWN

4c. County of Death

WASHINGTON

5. Social Security Number

372-24-4811

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

70

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

1/16/27

9. Birthplace (State or Foreign Country)

MICHIGAN

Usual Residence of Decedent

10a. State

WV

10b. County

BERKELEY

10c. City, Town or Location

MARTINSBURG

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

303 PRIMROSE DR.

10f. Zip Code

25401

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: 11/3/45 to 11/26/46

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

SUPERVISOR

16b. Kind of Business/Industry

HANDY & HARMON/FACTORY

17. Father's Name (First, Middle, Last)

JAMES J. GREENAN

18. Mother's Name (First, Middle, Maiden Surname)

IDA WAHOLTZ

19a. Informant's Name/Relationship (Type, Print)

CHRISTINE HADEN GREENAN/WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

303 PRIMROSE DR., MARTINSBURG, WV 25401

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

SMITHSBURG CREMATORY

Date

12/17/97

20c. Location - City or Town, State

SMITHSBURG, MD

21. Signature of Funeral Service Licensee

Charles M. Brown

22. Name and Address of Facility

BROWN FUNERAL HOME, PO BOX 821

327 W. KING ST., MARTINSBURG, WV 25402

23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

Cardio-respiratory arrest

Due to (or as a consequence of):

b.

myocardia Infarction

Due to (or as a consequence of):

c.

cerebro vascular accident

Due to (or as a consequence of):

d.

hypertension

Approximate interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

End Stage Renal disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Bruce Pulivarti, MD

29c. License number

D20233

29d. Date signed (Month, Day, Year)

12/12/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BAPURAO PULIVARTI 12931 OAK HILL AVE HAGERSTOWN MD 21422

31. Date filed (Month, Day, Year)

DEC 23 1997

32. Registrar's Signature

Johanna Davidson-Russell

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

12-11-54

Dear Mr. [illegible]

I have your letter of [illegible]

of [illegible] and [illegible]

and [illegible] and [illegible]

and [illegible] and [illegible]

and [illegible] and [illegible]

and [illegible] and [illegible]

and [illegible] and [illegible]

and [illegible] and [illegible]

and [illegible] and [illegible]

and [illegible] and [illegible]

and [illegible] and [illegible]

and [illegible] and [illegible]

and [illegible] and [illegible]

and [illegible] and [illegible]

and [illegible] and [illegible]

and [illegible] and [illegible]

and [illegible] and [illegible]

and [illegible] and [illegible]

and [illegible] and [illegible]

and [illegible] and [illegible]

and [illegible] and [illegible]

and [illegible] and [illegible]

and [illegible] and [illegible]

and [illegible] and [illegible]

and [illegible] and [illegible]

and [illegible] and [illegible]

and [illegible] and [illegible]

and [illegible] and [illegible]

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38695

Physician
/Medical
Examiner

Funeral
Director

| | | | | | |
|--|--|---|--|--|--|
| 1. Decedent's Name (First, Middle, Last) Wade Gooden Goodwin, Jr. | | 2. Date of Death Month December Day 20 Year 1997 | | 3. Time of Death 5:40 PM | |
| 4a. Facility Name (If not institution, give street and number) Maryland General Hospital | | 4b. City, Town, or Location of Death Baltimore | | 4c. County of Death N/A | |
| 5. Social Security Number 246-46-1633 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 65 Yrs. | |
| 8. Date of Birth (Month, Day, Year) Oct. 9, 1932 | | 9. Birthplace (State or Foreign Country) SC | | | |
| Usual Residence of Decedent | | | | | |
| 10a. State MD | | 10b. County n/a | | 10c. City, Town or Location Baltimore | |
| 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| 10e. Street and Number 1948 W. North Ave. | | 10f. Zip Code 21217 | | 10g. Citizen of What Country? USA | |
| 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 53'-56' | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | |
| 14. Race - American Indian, Black, White, etc. Specify: Black | | | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11th College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Supervisor | | 16b. Kind of Business/Industry Farm Stores | |
| 17. Father's Name (First, Middle, Last) Wade Goodwin | | 18. Mother's Name (First, Middle, Maiden Surname) Annie Mills | | | |
| 19a. Informant's Name/Relationship (Type, Print) Lillie M. Moore/aunt | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1948 W. North Ave. Balto., MD 21217 | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Garrison Forest VA | | 20c. Date 12/29 | |
| 20d. Location - City or Town, State Owings Mills, MD | | | | | |
| 21. Signature of Funeral Service Licensee  | | 22. Name and Address of Facility James A. Morton & Sons Funeral Home 1701 Laurens St. Balto., MD 21217 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | |
| Immediate Cause (Final disease or condition resulting in death) | | Approximate Interval Between Onset and Death | | | |
| a. Massive Intracerebral Bleed | | 4-5 days | | | |
| Due to (or as a consequence of): | | | | | |
| b. Respiratory Arrest | | | | | |
| Due to (or as a consequence of): | | | | | |
| c. Bleeding Disorder | | | | | |
| Due to (or as a consequence of): | | | | | |
| d. | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | |
| 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | | | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | |
| 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | |
| 29b. Signature and title of certifier  | | 29c. License number 89276 | | 29d. Date signed (Month, Day, Year) 12/20/97 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rupinder Singh, M.D. c/o Maryland General Hospital | | | | | |
| 31. Date filed (Month, Day, Year) DEC 23 1997 | | 32. Registrar's Signature  | | | |

To Be Completed by Funeral Director

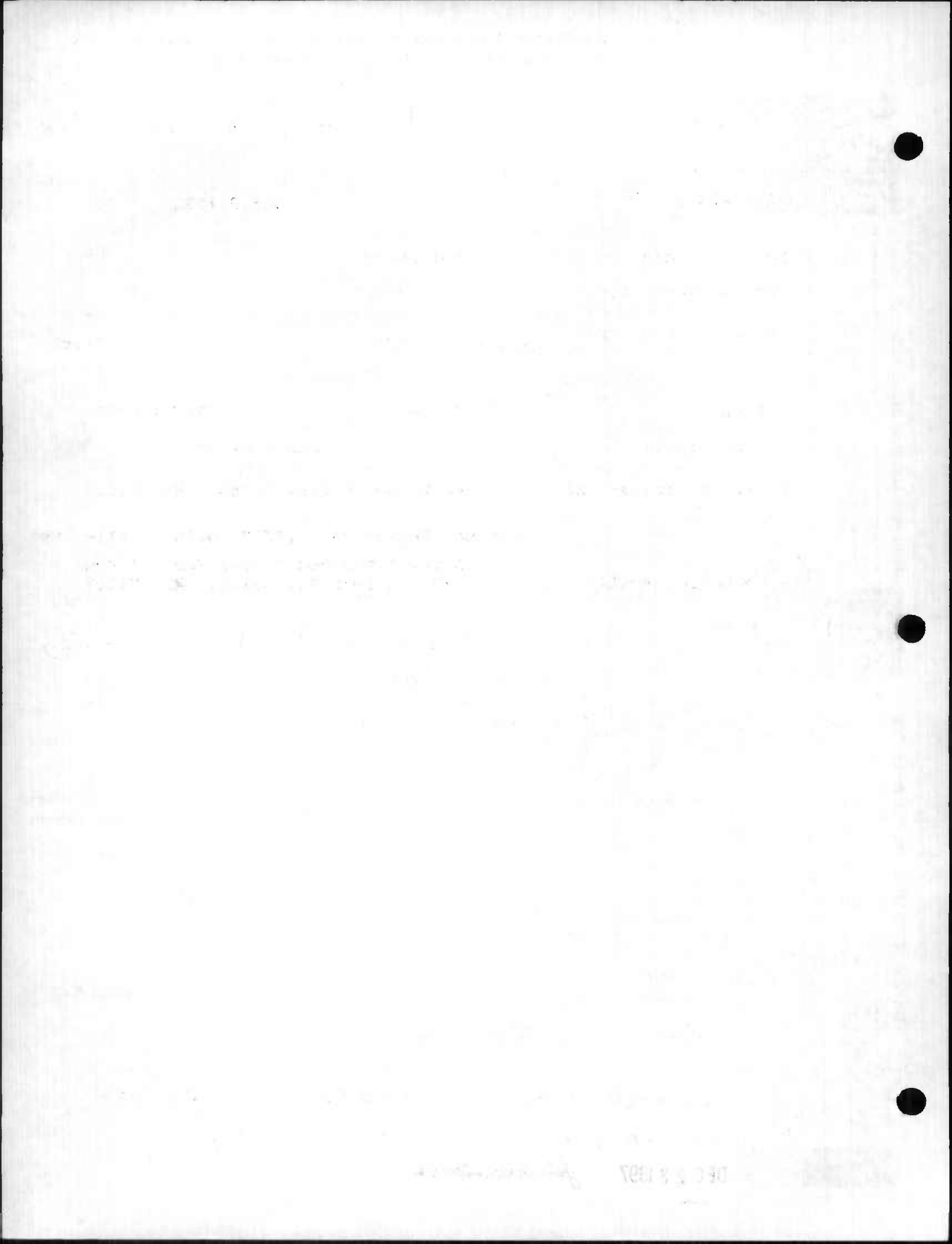
To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 38696

Certificate of Death

Reg. No.

BERNARD
GIBSON JR.Physician
/Medical
ExaminerFuneral
Director

| | | | | | |
|--|--|---|--|--|--|
| 1. Decedent's Name (First, Middle, Last) BERNARD A. GIBSON, JR. | | 2. Date of Death Month Day Year DECEMBER 20, 1997 | | 3. Time of Death 7:53 P.M. | |
| 4a. Facility Name (If not institution, give street and number) JOHNS HOPKINS HOSPITAL | | 4b. City, Town, or Location of Death BALTIMORE | | 4c. County of Death N/A | |
| 5. Social Security Number 213-90-3919 | | 6. Sex 10 M 20 F | | 7. Age (In yrs. last birthday) 20 Yrs. | |
| 8. Date of Birth (Month, Day, Year) JUNE 18, 1977 | | 9. Birthplace (State or Foreign Country) MARYLAND | | | |
| Usual Residence of Decedent | | | | | |
| 10a. State MARYLAND | | 10b. County N/A | | 10c. City, Town or Location BALTIMORE CITY | |
| 10d. Inside City Limits 1 X Yes 20 No | | | | | |
| 10e. Street and Number 220 N. WOLFE STREET | | 10f. Zip Code 21231 | | 10g. Citizen of What Country? U.S.A. | |
| 11. Marital Status 1 X Never Married 20 Married 30 Widowed 40 Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 10 Yes 20 No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 10 Yes 20 No Specify: | |
| 14. Race - American Indian, Black, White, etc. Specify: NEGRO | | | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11TH College (1-4 or 5+) N/A | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) CONSTRUCTION | | 16b. Kind of Business/Industry THE DOOR | |
| 17. Father's Name (First, Middle, Last) BERNARD A. GIBSON SR. | | 18. Mother's Name (First, Middle, Maiden Surname) WANDA D. HARRIS | | | |
| 19a. Informant's Name/Relationship (Type, Print) BERNADINE CROOK / AUNT | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4747 HOMESDALE AVE. BALTO, MD. 21206 | | | |
| 20a. Method of Disposition 1 X Burial 20 Cremation 30 Removal from State 40 Donation 50 Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) MT. ZION CEMETERY | | 20c. Location - City or Town, State DEC. 27, 1997 BALTIMORE, MD. | |
| 21. Signature of Funeral Service Licensee <i>Calvin B. Scruggs, Jr.</i> | | 22. Name and Address of Facility CALVIN B. SCRUGGS FUNERAL HOME 1412 E. PRESTON STREET BALTO, MD. 21213 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Gunshot wound of chest Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | Approximate Interval Between Onset and Death | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 23b. Did tobacco use contribute to the cause of death? 10 Yes 20 No 30 Probably 40 Unknown | |
| | | | | 24a. Was an autopsy performed? 10 Yes 20 No | |
| | | | | 24b. Were autopsy findings available prior to completion of cause of death? 10 Yes 20 No | |
| 25. Was case referred to medical examiner? 1 X Yes 20 No | | 26. Place of Death (Check only one) Hospital: 10 Inpatient 20 VER/Outpatient 30 DOA Other: 40 Nursing Home 50 Residence 80 Other (Specify) | | | |
| 27. Manner of Death 10 Natural 20 Accident 30 Suicide 40 Homicide 50 Pending investigation 60 Could not be determined | | 28a. Date of Injury (Month, Day, Year) 12-20-97 | | 28b. Time of Injury 1935 M | |
| | | 28c. Injury at Work? 10 Yes 20 No | | 28d. Describe how injury occurred Submerged shot | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Street | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) 900 Blk Village St. | |
| 29a. Certifier (Check only one) 10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated. 20 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier <i>Andriana</i> | | 29c. License number O.C.M.F. | |
| | | 29d. Date signed (Month, Day, Year) DECEMBER 21, 1997 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 | | | | | |
| 31. Date filed (Month, Day, Year) DEC 23 1997 | | 32. Registrar's Signature <i>Julia Davidson-Randall</i> | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 38697

Item#18 per FH G757 3/02/98 EW

Certificate of Death

Reg. No.

| | | | | | | | | | | | | | | |
|---|--|--|---|---|---|--|---|--|--|--|--------------------------------------|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) ANNA MAY GARY | | | 2. Date of Death Month December Day 18 Year 1997 | | | 3. Time of Death 6 AM | | | | | | | |
| | 4a. Facility Name (If not institution, give street and number) GENESIS ELDER CARE HOMEWOOD CENTER | | | 4b. City, Town, or Location of Death BALTIMORE | | | 4c. County of Death N/A | | | | | | | |
| Funeral Director | 5. Social Security Number 217-07-5643 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 89 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) MAY 06, 1908 | | 9. Birthplace (State or Foreign Country) NORTH CAROLINA | | | | | |
| | Usual Residence of Decedent | | | | | | | | | | | | | |
| To Be Completed by Funeral Director | 10e. State MARYLAND | | 10b. County N/A | | 10c. City, Town or Location BALTIMORE CITY | | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| | 10e. Street and Number 3247 YOSEMITE AVENUE | | | | 10f. Zip Code 21215 | | 10g. Citizen of What Country? USA | | | | | | | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: BLACK | | | | | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4TH GRADE College (1-4 or 5+) | | | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) DOMESTIC WORKER PRIVATE FAMILIES | | | 16b. Kind of Business/Industry | | | | | | | |
| | 17. Father's Name (First, Middle, Last) GRAY | | | 18. Mother's Name (First, Middle, Maiden Surname) WESLEY ERTIE HILL | | | | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) OLIVIA CARROLL (NEICE) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3247 YOSEMITE AVE. BALTIMORE, MD. 21215 | | | | | | | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) KING MEMORIAL PARK | | | 20c. Location - City or Town, State 12-23-97 WOODLAWN, MD. | | 20d. Date | | | | | | |
| | 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility JOSEPH H. BROWN JR. FUNERAL HOME 2140 N. FULTON AVE. BALTIMORE, MD. 21217 | | | | | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) SEPSIS Due to (or as a consequence of): Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last HYPERTENSION DEMENTIA Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CORONARY ARTERY DISEASE | | | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | |
| | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. Describe how injury occurred | | | | | | | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | 29b. Signature and title of certifier | | 29c. License number D47945 | | 29d. Date signed (Month, Day, Year) 12/19/97 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. ALEEM GENESIS ELDER CARE HOMEWOOD CENTER, 6000 BELLONA AVE BALTO. MD. 21212 | | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 23 1997 | | | | 32. Registrar's Signature | | | | | | | | | | |

Baltimore, Maryland 21215-0020

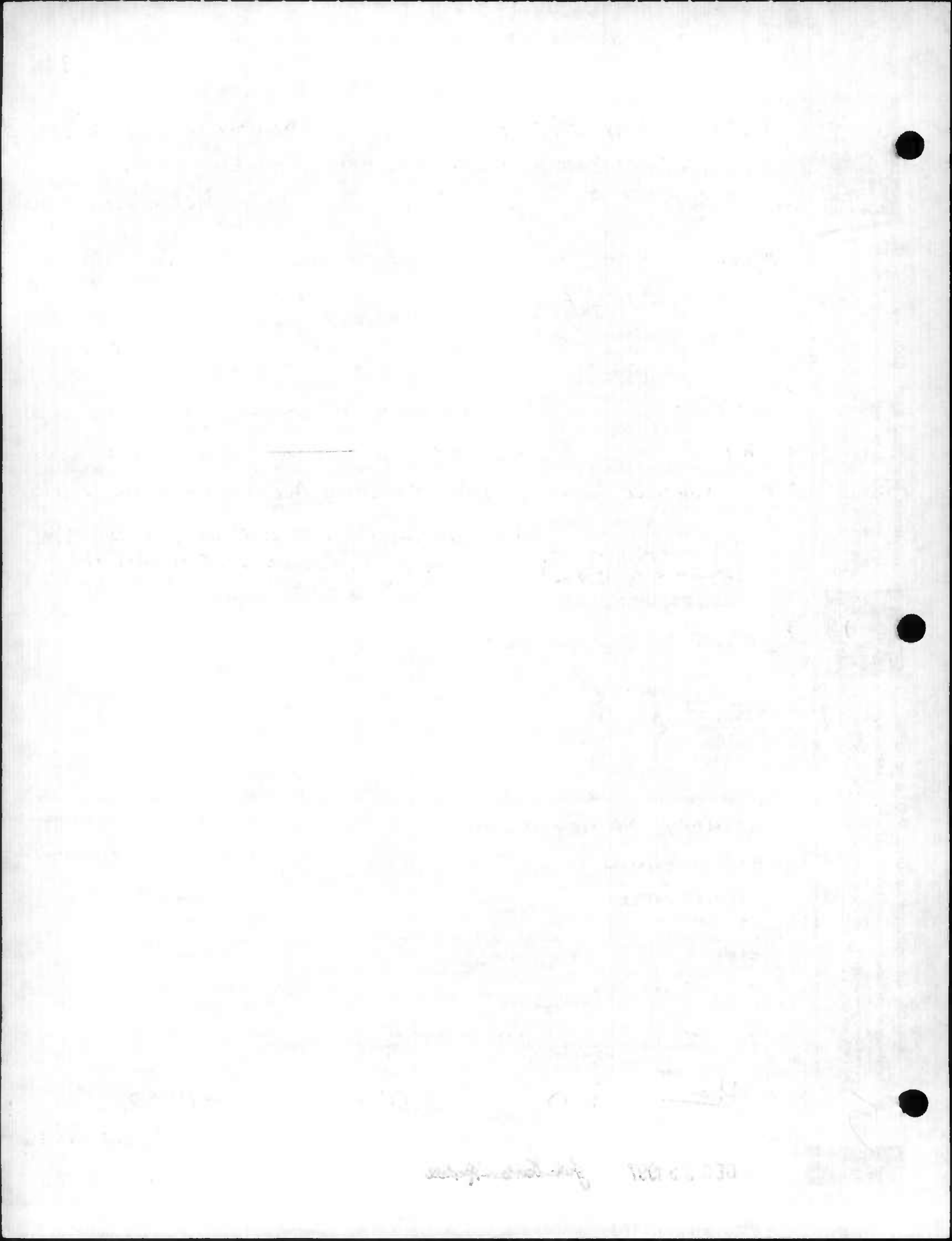
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38698

Item#19b perFH G754 12/23/97 EW

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

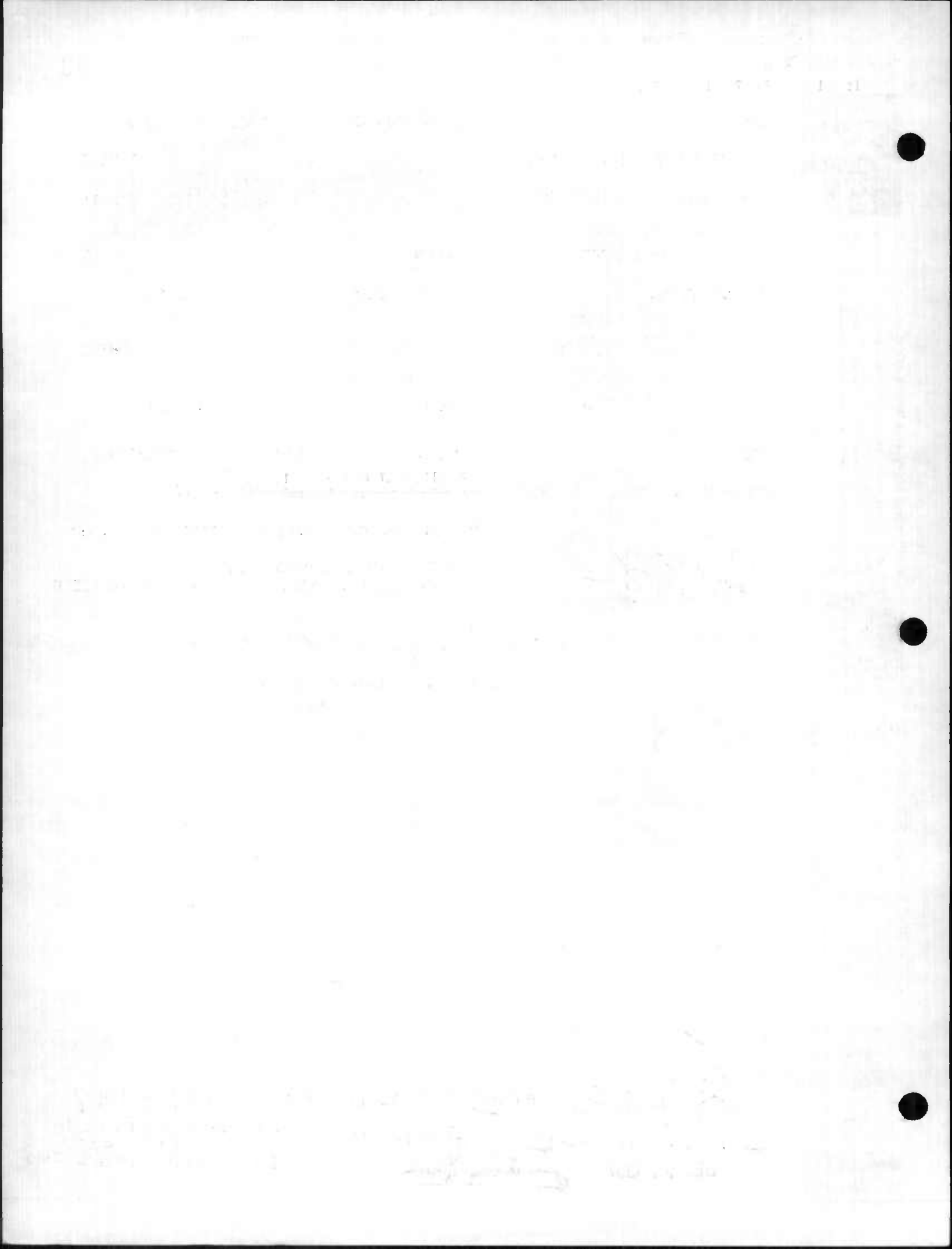
Medical Certification: To Be Completed by Physician/Medical Examiner

Physician /Medical Examiner

Funeral Director

| | | | | | | | |
|---|--|--|--|--|--------------------------------|---|--|
| 1. Decedent's Name (First, Middle, Last) MIRA GOLBKHAYER | | | | 2. Date of Death Month DEC. Day 19 Year 1997 | | 3. Time of Death 11:06am | |
| 4a. Facility Name (If not institution, give street and number) GREATER BALTO. MEDICAL CENTER | | | | 4b. City, Town, or Location of Death TOWSON | | 4c. County of Death BALTIMORE | |
| 5. Social Security Number 213-35-5323 | | 6. Sex 1 M 2 F | 7. Age (In yrs. last birthday) 76 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) JULY 14, 1921 | |
| 9. Birthplace (State or Foreign Country) RUSSIA | | | | | | | |
| 10a. State MD | | 10b. County BALTIMORE | | 10c. City, Town or Location TOWSON | | 10d. Inside City Limits 1 Yes 2 No | |
| 10e. Street and Number 27 BELLOWS CT. | | | | 10f. Zip Code 21204 | | 10g. Citizen of What Country? RUSSIA | |
| 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) TEACHER | | 16b. Kind of Business/Industry EDUCATION | |
| 17. Father's Name (First, Middle, Last) ENOCH AVEZHANSKY | | | | 18. Mother's Name (First, Middle, Maiden Surname) RAISA AVEZHANSKY | | | |
| 19a. Informant's Name/Relationship (Type, Print) YEVGENIYA GOLBKHAYER (DAUG.) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 BELLOWS CT. TOWSON MD 21204 27 BELLOWS CT. TOWSON, MD 21117 | | | |
| 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) BALTIMORE HEBREW | | Date 12/21/97 | | 20c. Location - City or Town, State REISTERSTOWN, MD | |
| 21. Signature of Funeral Service Licensee  | | | | 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN RD., PIKESVILLE, MD 21208 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Acute Myocardial Infarction. sudden Due to (or as a consequence of): b. Cardiac arrhythmia Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown | |
| | | | | | | 24a. Was an autopsy performed? 1 Yes 2 No | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No | |
| 25. Was case referred to medical examiner? 1 Yes 2 No | | 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) | | | | | |
| 27. Manner of Death 1 Natural 5 Pending investigation 2 Accident 6 Could not be determined 3 Suicide 4 Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 Yes 2 No | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28d. Describe how Injury occurred | | | |
| | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| 29b. Signature and title of certifier  | | | | 29c. License number D 15533 | | 29d. Date signed (Month, Day, Year) 12/19/97 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHRYSOLOGUE GAKUBA, 2 Reservoir Circle Ste 105 Pikesville Md 21208 | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 23 1997 | | | | 32. Registrar's Signature  | | | |

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38699

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

HARRY EARL GANNON

2. Date of Death

Month Day Year
December 20, 1997

3. Time of Death

16:05

4a. Facility Name (If not institution, give street and number)

SAINT AGNES HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

Funeral
Director

5. Social Security Number

217-09-6198

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

79

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
SEP. 7, 1918

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

BALTIMORE

10c. City, Town or Location

CATONSVILLE

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

222 GRALAN ROAD

10f. Zip Code

21228

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☒ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☒ Yes ☐ No
If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

INSPECTOR

16b. Kind of Business/Industry

CONSTRUCTION

17. Father's Name (First, Middle, Last)

CHESTER F. GANNON

18. Mother's Name (First, Middle, Maiden Surname)

EVA KOZLOWSKI

19a. Informant's Name/Relationship (Type, Print)

ANNETTE M. GANNON, WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

222 GRALAN ROAD, CATONSVILLE, MARYLAND 21228

20a. Method of Disposition

☐ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☒ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

ENTOMBMENT

LOUDON PARK MAUSOLEUM

Date

12/24/97 BALTIMORE, MARYLAND

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

R. Co. W. H. f

22. Name and Address of Facility

WITZKE FUNERAL HOMES, INC.

1630 EDMONDSON AVENUE, CATONSVILLE, MD 21228

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

ORGANIZING PNEUMONIA, RIGHT LUNG

Months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Pulmonary Emphysema, Severe

23b. Did tobacco use contribute to the cause of death?

☒ Yes ☐ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☒ Yes ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

☒ Yes ☐ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☒ Inpatient ☐ ER/Outpatient ☐ DOA

26. Place of Death (Check only one)

Other: ☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending Investigation
☐ Accident ☐ Could not be determined
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dennis J. Fisher M.D.

29c. License number

D47380

29d. Date signed (Month, Day, Year)

December 22, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. David P. Frishberg St. Agnes HealthCare 900 Caton Avenue Baltimore, MD 21229

31. Date filed (Month, Day, Year)

DEC 23 1997

32. Registrar's Signature

John Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

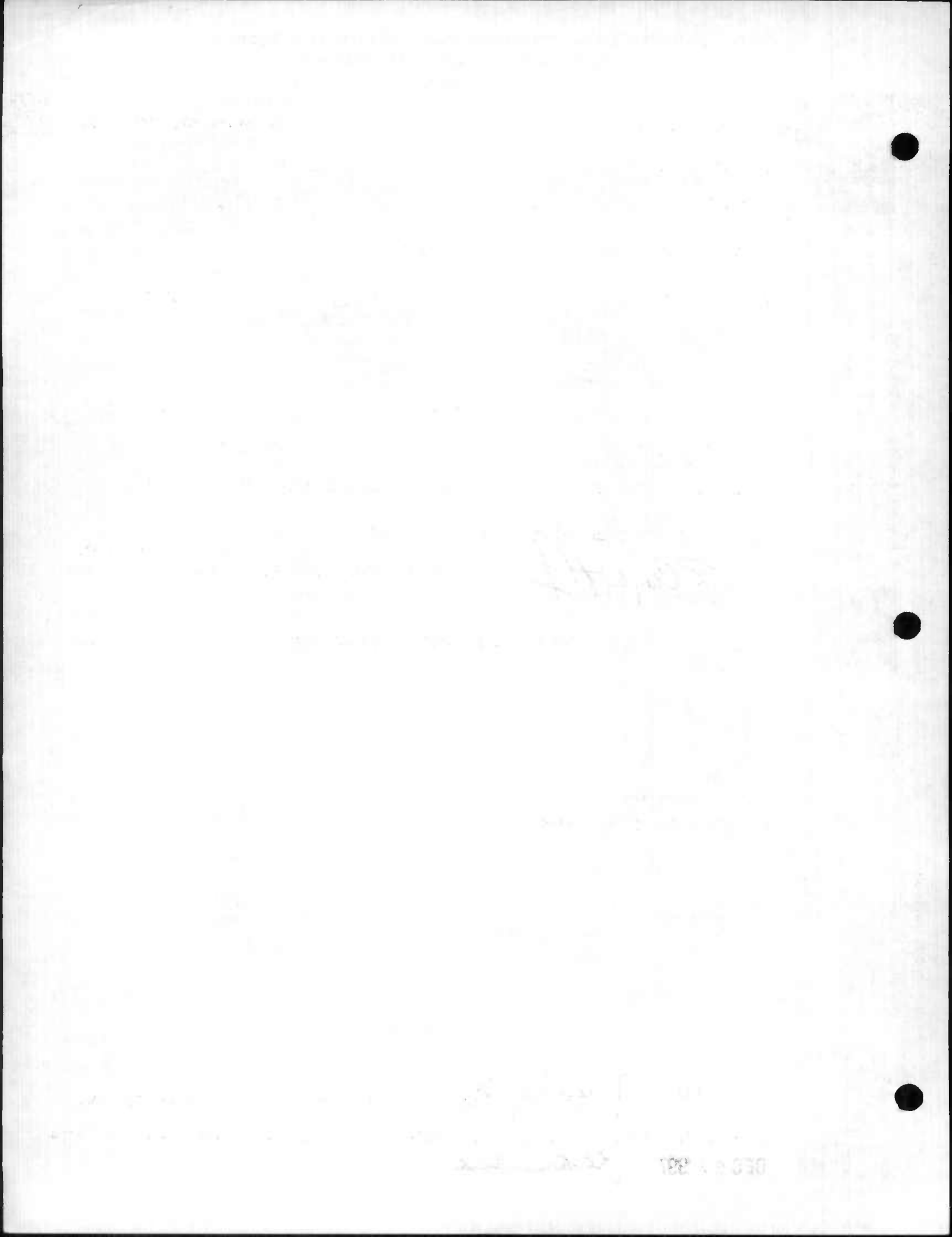
Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

HARRY GANNON

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38700

| | | | | | | | | | | |
|--|--|--|--|--|---|--|--------------------------------|-----------------------------------|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) RUTH S. GRESSITT | | | | 2. Date of Death Month Day Year DECEMBER 18, 1997 | | | | 3. Time of Death 11:00 A.M. | |
| | 4a. Facility Name (If not institution, give street and number) MARINER HEALTH CARE AT NORTH ARUNDEL | | | | 4b. City, Town, or Location of Death GLEN BURNIE | | | | 4c. County of Death ANNE ARUNDEL | |
| Funeral Director | 5. Social Security Number 343-38-5103 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 86 Yrs. | | If Under 1 Year Months Days | | If Under 24 Hrs. Hours Min. | |
| | 8. Date of Birth (Month, Day, Year) NOV. 21, 1911 | | 9. Birthplace (State or Foreign Country) MARYLAND | | 10. Usual Residence of Decedent 10a. State MARYLAND | | 10b. County ANNE ARUNDEL | | 10c. City, Town or Location GLEN BURNIE | |
| 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 10e. Street and Number 1221 GILFORD RD. | | 10f. Zip Code 21060 | | 10g. Citizen of What Country? UNITED STATES | | | | |
| 11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 3 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) REGISTERED NURSE | | 16b. Kind of Business/Industry HEALTH CARE | | | | | | |
| 17. Father's Name (First, Middle, Last) SAMUEL HUNLEY GRESSITT | | | | 18. Mother's Name (First, Middle, Maiden Surname) ARLENE SCOTT | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) ROBERT L. GRESSITT/ BROTHER | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1221 GILFORD RD., GLEN BURNIE, MARYLAND 21060 | | | | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) LORRAINE PARK CEMETERY | | Date DECEMBER 20, 1997 | | 20c. Location - City or Town, State WOODLAWN, MARYLAND | | | | |
| 21. Signature of Funeral Service Licensee | | 22. Name and Address of Facility KIRKLEY-RUDDICK FUNERAL HOME, P.A. 421 CRAIN HWY., S.E., GLEN BURNIE, MD 21061 | | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Acute Myocardial Infarction Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | Approximate Interval Between Onset and Death hours | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Dementia | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | | |
| 24e. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how Injury occurred | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier | | 29c. License number D 40521 | | 29d. Date signed (Month, Day, Year) DECEMBER 19, 1997 | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MAHESH S. OCHANAY, M.D., 3350 WILKINS AVE., BALTIMORE, MARYLAND 21229 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 23 1997 | | 32. Registrar's Signature | | | | | | | | |

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760,

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38701

| | | | | | | | | |
|--|---|---|--|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Thelma Alberta Goladay | | | | 2. Date of Death Month Day Year Dec. 20, 1997 | | 3. Time of Death 8:50 P.M. | |
| | 4a. Facility Name (If not institution, give street and number) Cherrywood Manor Nursing Home | | | | 4b. City, Town, or Location of Death Reisterstown | | 4c. County of Death Baltimore | |
| Funeral Director | 5. Social Security Number 216-68-7214 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 91 Yrs. | | 8. Date of Birth (Month, Day, Year) Oct. 21, 1906 | |
| | 9. Birthplace (State or Foreign Country) Brunswick, Md. | | 10. Usual Residence of Decedent 10a. State Md. | | 10b. County Frederick | | 10c. City, Town or Location Knoxville | |
| 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 10e. Street and Number 3655 Petersville Road | | 10f. Zip Code 21758 | | 10g. Citizen of What Country? USA | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10th Grade | | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Housewife | | 16b. Kind of Business/Industry Own Home | | | | |
| 17. Father's Name (First, Middle, Last) James Phillips | | | | 18. Mother's Name (First, Middle, Maiden Surname) Ruby Simons | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Mrs. Jeraldene J. Sigler | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3655 Petersville Road Knoxville, Md. 21758 | | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Arlington National Cem. | | 20c. Location - City or Town, State | | | | |
| 21. Signature of Funeral Service Licensee James B. Eline | | | | 22. Name and Address of Facility ELINE FUNERAL HOME 11824 Reisterstown Road Reisterstown, Md. 21136 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. <u>Severe dyspnea</u> Due to (or as a consequence of): b. <u>severe end stage dementia</u> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>severe dementia</u> <u>irreparable aortic aneurysm</u> | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier Steph Sigler MD | | 29c. License number 028304 | | 29d. Date signed (Month, Day, Year) 12/22/97 | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 750 Mann St Reisterstown MD 21136 | | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 23 1997 | | 32. Registrar's Signature John Henderson | | | | | | |

Baltimore, Maryland 21215-0020
Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Johnston Island

DEC 2 1961

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 38702
Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last) ALVIN GLICKMAN
2. Date of Death Month Day Year DEC. 15 1997
3. Time of Death 8:15 PM

Funeral
Director

4a. Facility Name (If not institution, give street and number) CHURCH HOME HOSPITAL
4b. City, Town, or Location of Death BALTIMORE
4c. County of Death N/A

5. Social Security Number 213-03-8366
6. Sex 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday) 90
8. Date of Birth (Month, Day, Year) NOV. 10, 1907
9. Birthplace (State or Foreign Country) MARYLAND

Usual Residence of Decedent

10a. State MD
10b. County BALTIMORE
10c. City, Town or Location BALTIMORE
10d. Inside City Limits 1 ☐ Yes 2 ☒ No

10e. Street and Number 16 STONEHENGE CIR., APT. 3
10f. Zip Code 21208
10g. Citizen of What Country? USA

11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No
13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) PROPRIETOR 16b. Kind of Business/Industry AUTOMOBILE REPAIR

17. Father's Name (First, Middle, Last) ROBERT GLICKMAN
18. Mother's Name (First, Middle, Maiden Surname) BESSIE LAMPE

19a. Informant's Name/Relationship (Type, Print) MRS. ANNE G. KAHN (DAUG.)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2302 JOLLY RD. BALTIMORE, MD 21209

20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place) BALTIMORE HEBREW 12/17/97
20c. Location - City or Town, State REISTERSTOWN, MD

21. Signature of Funeral Service Licensee
22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN RD., PIKESVILLE, MD 21208

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death) ALZHEIMER'S DISEASE
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
Due to (or as a consequence of):
Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

RENAL FAILURE
23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier
29c. License number D16619
29d. Date signed (Month, Day, Year) DEC. 18, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) C. VERGARA-SOARES 101 N. BOND ST. BALT. MD. 21231

31. Date filed (Month, Day, Year) DEC 23 1997
32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38703

| | | | | | | | | |
|---|---|---|--|--|--|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) CHEYENNE GRACE | | | | 2. Date of Death Month DECEMBER Day 16 , Year 1997 | | 3. Time of Death 0847 | |
| | 4a. Facility Name (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL | | | | 4b. City, Town, or Location of Death BALTIMORE CITY | | 4c. County of Death BALTIMORE | |
| Funeral Director | 5. Social Security Number 219-47-6472 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) Yrs. 15 | | 8. Date of Birth (Month, Day, Year) SEP. 19, 1996 | |
| | 9. Birthplace (State or Foreign Country) Md. | | 10a. State Md. | | 10b. County Baltimore | | 10c. City, Town or Location Middle River | |
| 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number 703 Wampler Road | | 10f. Zip Code 21220 | | 10g. Citizen of What Country? USA | | |
| 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) n/a | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) n/a | | 16b. Kind of Business/Industry n/a | | 17. Father's Name (First, Middle, Last) Timothy Grace | | |
| 18. Mother's Name (First, Middle, Maiden Surname) Tina Akers | | 19a. Informant's Name/Relationship (Type, Print) Timothy Grace/Father | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 703 Wampler Road Baltimore, Maryland 21220 | | 20. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | |
| 21. Signature of Funeral Service Licensee R. Terry Connolly | | 22. Name and Address of Facility Connolly Funeral Home of Essex 300 Mace Avenue Baltimore, Maryland 21221 | | 23a. Pert. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. List only one cause on each line. e. MYOCARDIAL FAILURE Due to (or as a consequence of): b. Tetralogy of Fallot with Pulmonary Atresia Due to (or as a consequence of): c. HEPATIC FAILURE Due to (or as a consequence of): d. RENAL FAILURE | | Approximate Interval Between Onset and Death 7 days 15 months 7 days 7 days | | |
| 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | |
| 28c. Injury et Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier Anne E. Natale MD | | 29c. License number RES-000 | | 29d. Date signed (Month, Day, Year) DECEMBER 16, 1997 | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Anne E. Natale, MD The Johns Hopkins Hospital, Baltimore, Maryland | | 31. Date filed (Month, Day, Year) DEC 23 1997 | | 32. Registrar's Signature Jubia Davidson-Randall | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

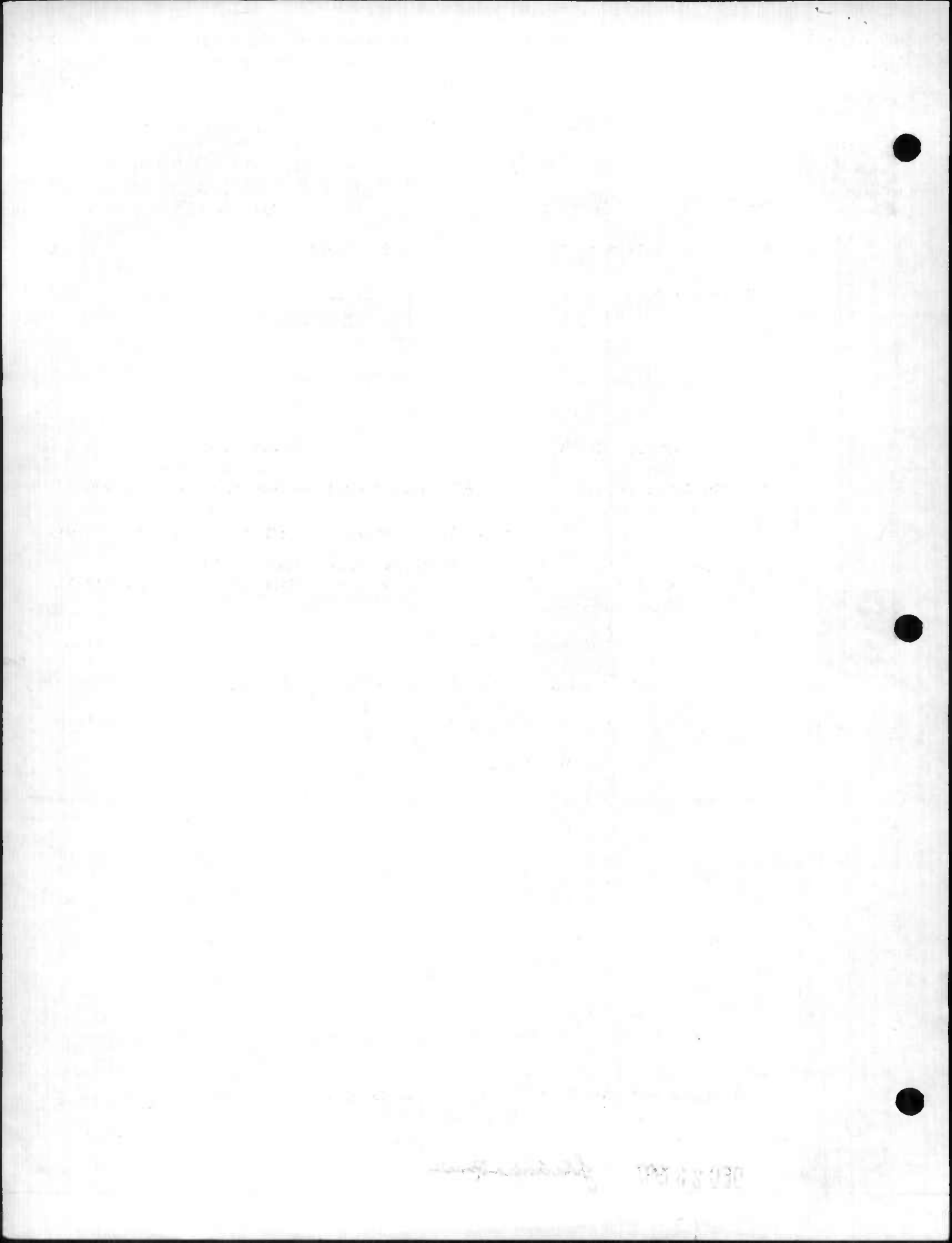
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38704

| | | | | | | | | | |
|---|---|---|---|--|--|--|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) ANNIE LEE HARRIS | | | | 2. Date of Death Month DECEMBER Day 21 Year 1997 | | 3. Time of Death 2:00 PM | | |
| | 4a. Facility Name (If not institution, give street and number) Saint Joseph Medical Center | | | | 4b. City, Town, or Location of Death Towson | | 4c. County of Death Baltimore | | |
| Funeral Director | 5. Social Security Number 245-42-2529 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (in yrs. last birthday) 74 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) 7-23-23 | 9. Birthplace (State or Foreign Country) North Carolina | |
| | Usual Residence of Decedent | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State Maryland | 10b. County N/A | 10c. City, Town or Location Baltimore | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| | 10e. Street and Number 6021 Loch Raven Blvd | | | 10f. Zip Code 21239 | | 10g. Citizen of What Country? U.S.A. | | | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: BLACK | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Dietician | | 16b. Kind of Business/Industry Kernan Hosp. | | | | |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last) Hebrew Carr | | | | 18. Mother's Name (First, Middle, Maiden Surname) Gussie Grimes | | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Mr. Louis Carr (Son) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7711 Riverdale Rd Apt 13 New Carrollton, Md 20784 | | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Council Cem | | 20c. Location - City or Town, State Bethel, N.C. | | | | |
| | 21. Signature of Funeral Service Licensee Joseph L. Russ | | 22. Name and Address of Facility Joseph L. Russ FUNERAL HOME 2322 W. North Ave. Baltimore Md 21226 | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. SEPSIS Due to (or as a consequence of): b. RECURRENT SMALL CELL CARCINOMA OF BLADDER Due to (or as a consequence of): c. WITH BRAIN METASTASES Due to (or as a consequence of): d. | | | | | | | | Approximate Interval Between Onset and Death DAYS 4 YEARS | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DIABETES MELLITUS | | | | | | 23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | |
| | | | | | | 24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | | 28a. Place of injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| 29b. Signature and title of certifier Beatriz P. Dizon, M.D. | | | | 29c. License number D 16492 | | 29d. Date signed (Month, Day, Year) Dec. 22, 1997 | | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) BEATRIZ P. DIZON, M.D. 7620 YORK ROAD, TOWSON, MARYLAND 21204 | | | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 23 1997 | | | | 32. Registrar's Signature Julia Davidson-Randall | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

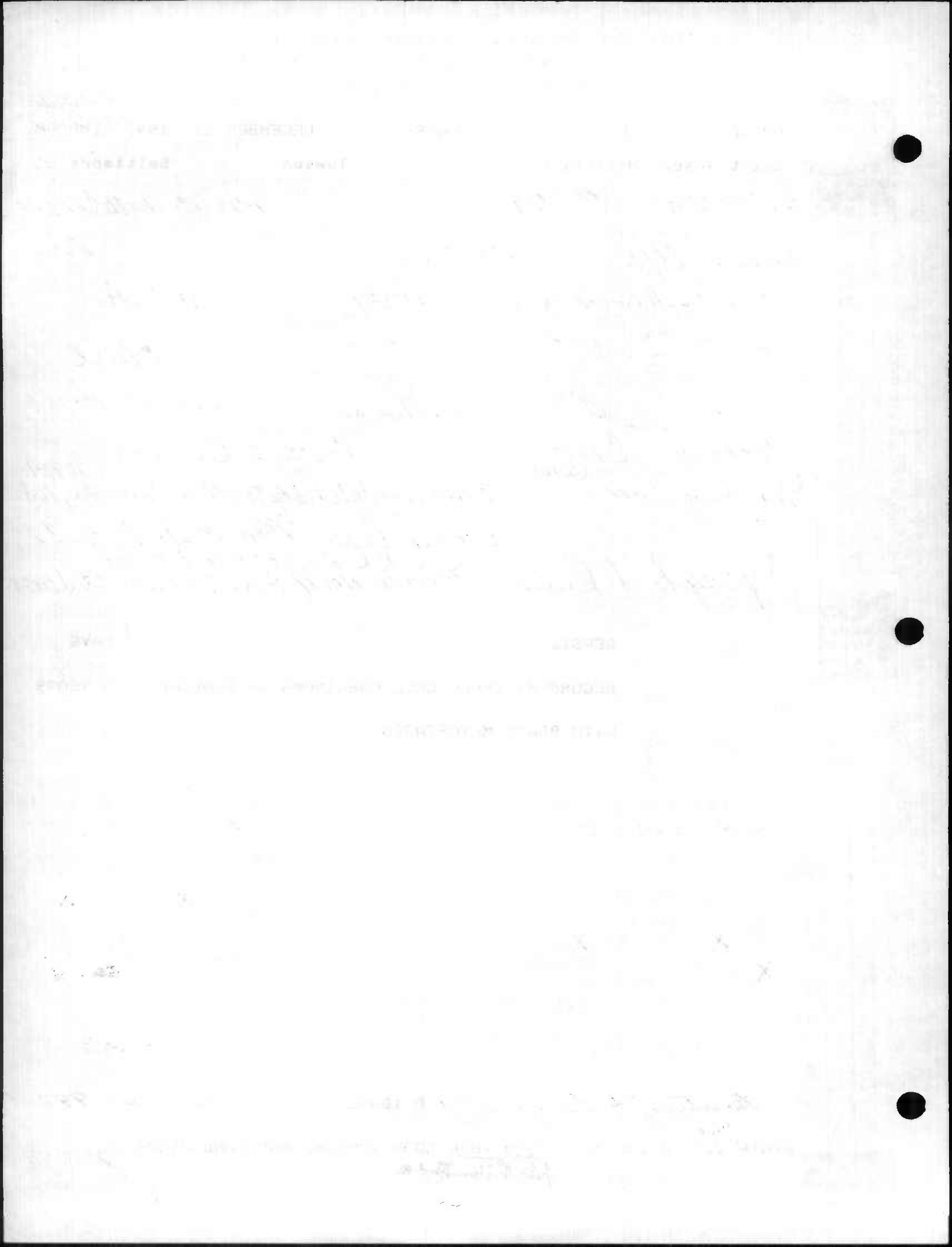
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State
Registrar



97-7163-510

CSP

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Items: 23a Part Ia, 27, 28a-f Per Meo Film G-754 12-31-97RC

Certificate of Death

Reg. No.

97 38705

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

John Thomas (J.T.) Householder

2. Date of Death

Month 12 Day 13 Year 97

3. Time of Death

0541AM

4a. Facility Name (If not institution, give street and number)

Liberty Medical Center E.R.

4b. City, Town, or Location of Death

Baltimore City

4c. County of Death

N/A

5. Social Security Number

402028335

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

33 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
10 04 64

9. Birthplace (State or Foreign Country)

Texas

Usual Residence of Decedent

10a. State

Ky

10b. County

10c. City, Town or Location

Henderson

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1424 Woodland Drive Apt. 14

10f. Zip Code

42420

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (14 or 5+)

0

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Steel Worker

16b. Kind of Business/Industry

Nationwide Towers

17. Father's Name (First, Middle, Last)

Kestner Allen Householder

18. Mother's Name (First, Middle, Maiden Surname)

Flor a Evalyn Householder

19a. Informant's Name/Relationship (Type, Print)

Mark Householder

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1424 Woodland Dr. Henderson, Ky 42420

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

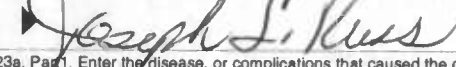
20b. Place of Disposition (Name of cemetery, crematory or other place)

Roselawn Mem. Gardens 12/18/97 Henderson, Ky

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

Joseph I. Russ F/H 2222 W. North Ave.

21216

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

ALCOHOL & NARCOTIC INTOXICATION

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide5 ☐ Pending Investigation6 ☒ Could not be determined

28a. Date of Injury (Month, Day, Year)

12/13/97

28b. Time of Injury

Unknown M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

Unknown

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Friend's House

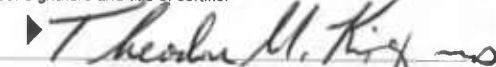
28f. Location (Street and Number or Rural Route Number, City or Town, State)

3651 Cottage Avenue, Baltimore, Md.

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier



29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

DECEMBER 19, 1997


30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

THEODORE M. KING 111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

DEC 23 1997

32. Registrar's Signature



Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

100-11-5P
94

100-11-5P
94

100-11-5P
94

100-11-5P
94

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38706

Physician
/Medical
Examiner

Funeral
Director

| | | | | | |
|---|--|---|--|---|--|
| 1. Decedent's Name (First, Middle, Last) <i>Kathleen Ann Hunt</i> | | 2. Date of Death Month <i>December</i> Day <i>19</i> Year <i>1997</i> | | 3. Time of Death <i>8:55pm</i> | |
| 4a. Facility Name (If not institution, give street and number) <i>30 Bonbon Court</i> | | 4b. City, Town, or Location of Death <i>Reisterstown</i> | | 4c. County of Death <i>Baltimore</i> | |
| 5. Social Security Number <i>212-96-2272</i> | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) <i>31</i> Yrs. | |
| 8. Date of Birth (Month, Day, Year) <i>Oct. 25 1966</i> | | 9. Birthplace (State or Foreign Country) <i>Maryland</i> | | | |
| Usual Residence of Decedent | | | | | |
| 10a. State <i>Maryland</i> | | 10b. County <i>Baltimore</i> | | 10c. City, Town or Location <i>Reisterstown</i> | |
| 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number <i>30 Bonbon Court</i> | | 10f. Zip Code <i>21136</i> | |
| 10g. Citizen of What Country? <i>USA</i> | | 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | |
| 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: <i>White</i> | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12yrs</i> College (14 or 5+) <i>4yrs</i> | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>accountant</i> | | 16b. Kind of Business/Industry <i>Rouse Company</i> | |
| 17. Father's Name (First, Middle, Last) <i>Harry C. Walker Sr.</i> | | 18. Mother's Name (First, Middle, Maiden Surname) <i>Marlene Bihum</i> | | | |
| 19a. Informant's Name/Relationship (Type, Print) <i>Richard D. Hunt</i> | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>30 Bonbon Ct. Reisterstown, Md. 21136</i> | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Dulany Valley Mem. Garden</i> | | 20c. Location - City or Town, State <i>Timonium Maryland</i> | |
| 21. Signature of Funeral Service Licensee <i>Keisha S. Wells</i> | | 22. Name and Address of Facility <i>Evans Funeral Chapel 2325 York Rd. Timonium, Md 21093</i> | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | |
| Immediate Cause (Final disease or condition resulting in death) | | a. <i>Liver Failure</i> | | | Approximate Interval Between Onset and Death <i>weeks</i> <i>months</i> <i>year</i> |
| Due to (or as a consequence of): | | b. <i>Metastatic Colon Cancer</i> | | | |
| Due to (or as a consequence of): | | c. | | | |
| Due to (or as a consequence of): | | d. | | | |
| 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | |
| 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of injury (Month, Day Year) | | 28b. Time of Injury M | |
| 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | |
| 29b. Signature and title of certifier <i>Deborah A. Manning MD</i> | | 29c. License number <i>D0050842</i> | | 29d. Date signed (Month, Day, Year) <i>12-22-97</i> | |
| 30. Name and address of person who completed cause of death (Part 23a) (Type, Print) <i>Deborah A. Manning MD 3100 Wyman Park Dr. Balt. MD 21211</i> | | | | | |
| 31. Date filed (Month, Day, Year) <i>DEC 23 1997</i> | | 32. Registrar's Signature <i>Julia Davidson-Ponder</i> | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permitted. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38707

| | | | | | | | | | | |
|---|---|--|---|--|--|--|--|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) MINNIE ETHEL HANCOCK | | | | | | 2. Date of Death Month Day Year DECEMBER 19, 1997 | | 3. Time of Death 9:00a.m. | |
| | 4a. Facility Name (If not institution, give street and number) 3917 Belvue Avenue | | | | | | 4b. City, Town, or Location of Death Baltimore | | 4c. County of Death n/a | |
| Funeral Director | 5. Social Security Number 227-50-4515 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 59 Yrs. | | 8. Date of Birth (Month, Day, Year) Oct. 15, 1938 | | 9. Birthplace (State or Foreign Country) Va. | |
| | Usual Residence of Decedent | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State Md. | | 10b. County n/a | | 10c. City, Town or Location Baltimore | | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| | 10e. Street and Number 3917 Belvue Avenue | | | | 10f. Zip Code 21215 | | 10g. Citizen of What Country? USA | | | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: Black | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10th Grade | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Housekeeper | | 16b. Kind of Business/Industry Sinai Hospital | | | | | |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last) Bennie Dews | | | | | | 18. Mother's Name (First, Middle, Maiden Surname) Amanda Scott | | | |
| | 19a. Informant's Name/Relationship (Type, Print) daughter Joyce A. Ringo | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9589 El Cajon Drive Baton Rouge, La. 70815 | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Zion Baptist CH. Cem. | | 20c. Location - City or Town, State Dec. 24 Red House, Va. | | | |
| | 21. Signature of Funeral Service Licensee <i>[Signature]</i> | | | | 22. Name and Address of Facility Nutter Funeral Homes, Inc. 2501 Gwynns Falls PKWY Baltimore, Md. 21216 | | | | | |
| Physician /Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. SUDDEN CARDIOPULMONARY EVENT Due to (or as a consequence of): b. ACUTE MYOCARDIAL INFARCT Due to (or as a consequence of): c. HYPERTENSIVE ASCVD Due to (or as a consequence of): d. | | | | | | | | Approximate Interval Between Onset and Death | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. FLU LIKE SYMPTOMS; ACUTE VIRAL GASTROENTERITIS | | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how Injury occurred | |
| | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier <i>[Signature]</i> | | 29c. License number D14829 | | 29d. Date signed (Month, Day, Year) 12/23/97 | | | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) A.C. ENRIQUE M.D. 2435 W. BELVEDERE AVE | | | | | | | | | |
| | 31. Date filed (Month, Day, Year) DEC 23 1997 | | 32. Registrar's Signature <i>[Signature]</i> 21215 | | | | | | | |

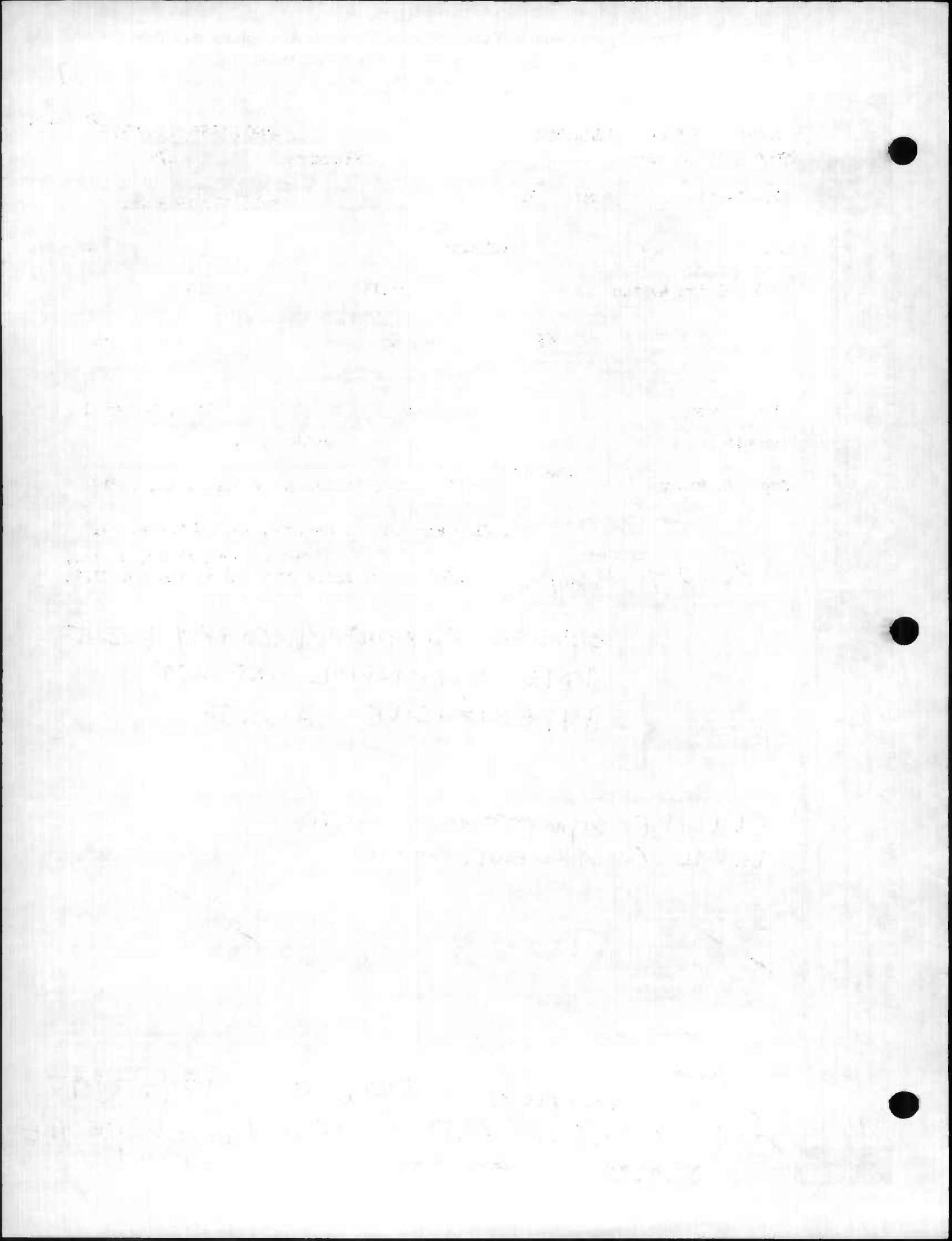
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38708

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

VIRGINIA C. HOLMAN

2. Date of Death

Month

Day

Year

12

20

97

3. Time of Death

12:30 AM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

HOWARD COUNTY GENERAL HOSPITAL

4b. City, Town, or Location of Death

COLUMBIA

4c. County of Death

HOWARD

5. Social Security Number

216-20-2322

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

72

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

5

16

25

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

HOWARD

10c. City, Town or Location

ELLICOTT CITY

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

02 CHATHAM ROAD

10f. Zip Code

21043

10g. Citizen of What Country?

US

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No

Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

-0-

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

OPERATOR

16b. Kind of Business/Industry

GOVERNMENT

17. Father's Name (First, Middle, Last)

FREDERICK CATLIN

18. Mother's Name (First, Middle, Maiden Surname)

PEARL PRINCE

19a. Informant's Name/Relationship (Type, Print)

MARCIA HOLMAN (DAUGHTER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5221 WAGON SHED CIRCLE OWINGSMILLS, MD. 21117

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

ST. JOHN CEMETERY 12/27 ELLICOTT CITY, MD.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

ELIZABETH L. PHILLIPS F?H 1721-27 N. MONROE STREET BALTIMORE, MD.

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. metastatic breast cancer
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

18 months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

M.D., Ph.D., Fellow

29c. License number

D0050772

29d. Date signed (Month, Day, Year)

December 23, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. David E. Syner, The Johns Hopkins Oncology Center, Baltimore, MD 21205

31. Date filed (Month, Day, Year)

DEC 23 1997

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

permx: Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38709

| | | | | | | | | |
|--|---|---|--|---|--|--|--|---|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) BERTHA AGNES HEINTZEMAN | | | | 2. Date of Death Month Day Year Dec. 19, 1997 | | 3. Time of Death 5:10 p.m. | |
| | 4e. Facility Name (If not institution, give street and number) 1743 W. Jarrettsville Road | | | | 4b. City, Town, or Location of Death Jarrettsville | | 4c. County of Death Harford | |
| Funeral Director | 5. Social Security Number 215-22-2502 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 71 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) Sept. 19, 1926 | 9. Birthplace (State or Foreign Country) Maryland |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State Maryland | | 10b. County Harford | | 10c. City, Town or Location Jarrettsville | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 10e. Street and Number 1743 W. Jarrettsville Road | | | | 10f. Zip Code 21084 | | 10g. Citizen of What Country? U.S.A. | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No, if Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10th grade College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker | | 16b. Kind of Business/Industry Own Home | | |
| 17. Father's Name (First, Middle, Last) Vincent Mazalewski | | | | 18. Mother's Name (First, Middle, Maiden Surname) Anna Gibowicz | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Charles H. Heintzeman (Son) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 819 Petem Road, Kingsville, MD. 21087 | | | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Green Mount Crematory | | Date 12/22/97 | | 20c. Location - City or Town, State Baltimore, Maryland | | |
| 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility Schimunek Funeral Home of Bel Air, Inc. 610 W. MacPhail Road, Bel Air, MD. 21014 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Acute Coronary artery disease Due to (or as a consequence of): b. ASCVD Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | |
| 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) NA | | 28b. Time of Injury NA M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) NA | | | | 28d. Describe how injury occurred NA | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) NA | | | | 28g. Location (Street and Number or Rural Route Number, City or Town, State) NA | | | | |
| 29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | 29b. Signature and title of certifier DME | | | | |
| 29c. License number OCME | | | | 29d. Date signed (Month, Day, Year) Dec 22nd 1997 | | | | |
| 30. Name and address of person who completed cause of death (Item 28e) (Type, Print) G.S. Prabhu 218 FULFORD RD BEL AIR MD. 21014 410-879-6564 | | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 23 1997 | | | | 32. Registrar's Signature | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38710

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ALMA C. HALL

2. Date of Death

Month Day Year
December 20 1997 12 30 AM

3. Time of Death

Funeral
Director

4a. Facility Name (If not institution, give street and number)

North Arundel Hospital

4b. City, Town, or Location of Death

Glen Burnie

4c. County of Death

Anne Arundel County

5. Social Security Number

219-16-0422

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

76 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year
1/17/1921

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

ANNE ARUNDEL

10c. City, Town or Location

GLEN BURNIE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

102 CRAIN HIGHWAY, N.

10f. Zip Code

21061

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married

3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

FRANK L. MEWSHAW, SR.

18. Mother's Name (First, Middle, Maiden Surname)

MARY L. KLUG

19a. Informant's Name/Relationship (Type, Print)

ALVA L. MEWSHAW

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

118 MAIN AVE, S.E., GLEN BURNIE, MD 21061

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

HOLY CROSS CEM.

Date

12/22

20c. Location - City or Town, State

BALTIMORE, MD.

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

RAYMOND C. FINK FUNERAL HOME
426 CRAIN HWY., SW GLEN BURNIE, MD 21061

23a. Part I. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. End Stage Chronic Obstructive Pulmonary Disease

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Years

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Congestive Heart Failure

Warfarin Necrosis Left leg

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural

2 ☐ Accident

3 ☐ Suicide

4 ☐ Homicide

5 ☐ Pending Investigation

6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

M

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

29c. License number

H40961

29d. Date signed (Month, Day, Year)

December 20, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Jeffrey Sagel North Arundel Hospital 301 Hospital Drive Glen Burnie, MD 21061

31. Date filed (Month, Day, Year)

DEC 23 1997

32. Registrar's Signature

[Signature]

State
Registrar

Name: Alma Hall
Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38711

| | | | | | | | | | |
|---|---|---|--|---|---|--|---|-----------------------------------|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) <i>CLARA Holland</i> | | | | 2. Date of Death Month <i>DECEMBER</i> Day <i>22</i> Year <i>1997</i> | | 3. Time of Death <i>03:45</i> | | |
| | 4a. Facility Name (If not institution, give street and number) <i>THE JOHNS HOPKINS HOSPITAL</i> | | | | 4b. City, Town, or Location of Death <i>BALTIMORE CITY</i> | | 4c. County of Death <i>N/A</i> | | |
| Funeral Director | 5. Social Security Number <i>220-12-7126A</i> | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) <i>87</i> Yrs. | | 8. Date of Birth (Month, Day, Year) <i>NOV. 27, 1910</i> | | |
| | 9. Birthplace (State or Foreign Country) <i>SOUTH CAROLINA</i> | | 10a. State <i>MARYLAND</i> | | 10b. County <i>N/A</i> | | 10c. City, Town or Location <i>BALTIMORE CITY</i> | | |
| To Be Completed by Funeral Director | Usual Residence of Decedent | | | | 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | |
| | 10e. Street and Number <i>1509 EDEN STREET</i> | | | | 10f. Zip Code <i>21213</i> | | 10g. Citizen of What Country? <i>U.S.A.</i> | | |
| | 11. Marital Status 1 <input type="checkbox"/> Navar Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <i>X</i> | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: <i>NEGRO</i> | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12TH</i> College (1-4 or 5+) <i>N/A</i> | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>RECEPTIONIST</i> | | 16b. Kind of Business/Industry <i>CAMBELL MEDICAL</i> | | | | |
| | 17. Father's Name (First, Middle, Last) <i>GEORGE FINKLEY</i> | | | | 18. Mother's Name (First, Middle, Maiden Surname) <i>DIANNE GREEN</i> | | | | |
| | 19a. Informant's Name/Relationship (Type, Print) <i>MICHAELLE H. NESBIT / daughter</i> | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>4109 ROLLINS AVENUE BALTO, MD. 21207</i> | | | | |
| | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) <i>CEDAR HILL CEMETERY</i> | | Date <i>dec. 24, 1997</i> | | 20c. Location - City or Town, State <i>ANNE ARUNDEL CO. MARYLAND</i> | | |
| | 21. Signature of Funeral Service Licensee <i>Calvin B. Scruggs, Jr.</i> | | 22. Name and Address of Facility <i>CALVIN B. SCRUGGS FUNERAL HOME 1412 E. PRESTON ST. BALTO, MD. 21213</i> | | | | | | |
| | 23a. Pertinent disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <i>Left frontal lobe hemorrhage</i> | | | | | | | | |
| | 23b. Approximate Interval Between Onset and Death <i>24 hours</i> | | | | | | | | |
| Physician /Medical Examiner | Immediate Cause (Final disease or condition resulting in death) <i>Left frontal lobe hemorrhage</i> | | | | | | | | |
| | Due to (or as a consequence of): | | | | | | | | |
| | Due to (or as a consequence of): | | | | | | | | |
| | Due to (or as a consequence of): | | | | | | | | |
| | Due to (or as a consequence of): | | | | | | | | |
| | Due to (or as a consequence of): | | | | | | | | |
| | Due to (or as a consequence of): | | | | | | | | |
| | Due to (or as a consequence of): | | | | | | | | |
| | Due to (or as a consequence of): | | | | | | | | |
| | Due to (or as a consequence of): | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>coronary artery disease</i> <i>hypertension</i> | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | | | | | | | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | |
| 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury <i>M</i> | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier <i>Calvin B. Scruggs, Jr. MD Anesthesia Resident</i> | | 29c. License number <i>Res - 000</i> | | 29d. Date signed (Month, Day, Year) <i>December 22, 1997</i> | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>The Johns Hopkins Hospital, 600 North Wolfe Street, Baltimore, Maryland</i> | | | | | | | | | |
| 31. Date filed (Month, Day, Year) <i>DEC 23 1997</i> | | 32. Registrar's Signature <i>Jane Davidson-Randall</i> | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38712

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

George

HARRISON

2. Date of Death

December 6, 1997

3. Time of Death

2:49 am

4a. Facility Name (If not institution, give street and number)

Franklin Square Hospital Center

4b. City, Town, or Location of Death

Rosedale

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

217-22-7578

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

69 Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

April 19, 1928

9. Birthplace (State or Foreign Country)

unknown

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

55 Beach Drive

10f. Zip Code

21220

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces? ☐ Yes 2 ☐ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☐ No Specify:

unknown

14. Race - American Indian,

Black, White, etc.

Specify:

white

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

unknown

College (1-4 or 5+)

unknown

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

unknown

16b. Kind of Business/Industry

unknown

17. Father's Name (First, Middle, Last)

unknown

18. Mother's Name (First, Middle, Maiden Surname)

unknown

19a. Informant's Name/Relationship (Type, Print)

unknown

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

unknown

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☒ Other (Specify) in state

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Ronald S. Wade, Director

22. Name and Address of Facility

State Anatomy Board, 655 W. Baltimore St.

Baltimore, MD 21201

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Hypoxemia

Approximate Interval Between Onset and Death

6 minutes

Due to (or as a consequence of):

Myocardial Infarction

2 hours

Due to (or as a consequence of):

Coronary Artery Disease

30 years

Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Peripheral Vascular Disease

Diabetes Mellitus Type II

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

RD1926

29d. Date signed (Month, Day, Year)

December 6, 1997

30. Name and address of person who completed cause of death (item 23e) (Type, Print)

John Kim M.D. 9000 Franklin Square Drive Baltimore, Maryland 21237

31. Date filed (Month, Day, Year)

DEC 23 1997

32. Registrar's Signature

John Kim M.D.

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

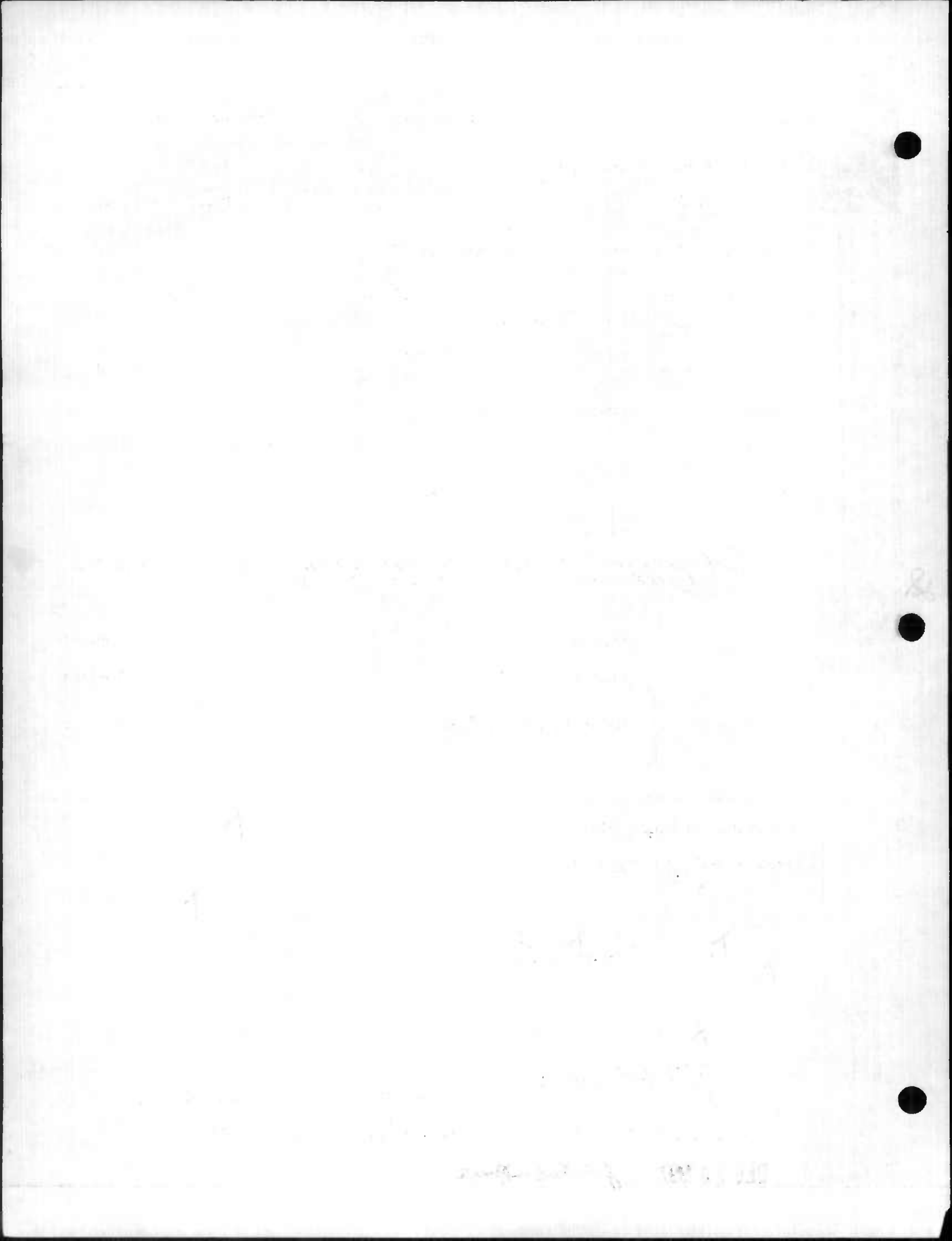
Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38713

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

CLIFFORD L. HENSLEY

2. Date of Death

Month Day Year
Dec. 17, 1997

3. Time of Death

2:08 A. M.

4a. Facility Name (If not institution, give street and number)

80 Transverse Avenue

4b. City, Town, or Location of Death

Middle River

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

218-42-3192

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

54 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
July 15, 1943

9. Birthplace (State or Foreign Country)

Arkansas

Usual Residence of Decedent

10a. State

Md.

10b. County

Baltimore

10c. City, Town or Location

Middle River

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

80 Transverse Avenue

10f. Zip Code

21220

10g. Citizen of What Country?

USA

11. Marital Status

☐ Navar Married ☒ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☐ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2 yrs.

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Private Investigator

16b. Kind of Business/Industry

self-employed

17. Father's Name (First, Middle, Last)

Clifford Hensley

18. Mother's Name (First, Middle, Maiden Surname)

Vivian Twyford

19a. Informant's Name/Relationship (Type, Print)

Eileen L. Hensley/wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

80 Transverse Avenue Baltimore, Md. 21220

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Belair Memorial Gardens 12/20/97 Belair, Md.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

R. Terry Connelly

22. Name and Address of Facility

Connelly Funeral Home of Essex
300 Mace Avenue Baltimore, Md. 21221

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Brain Metastases

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Non-small cell carcinoma of the Lung

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☒ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient

☐ ER/Outpatient

☐ DOA

Other:

☐ Nursing Home

☒ Residence

☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation
☐ Accident ☐ Could not be determined
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Wen-sen Hsieh, M.D.

29c. License number

D52257

29d. Date signed (Month, Day, Year)

12/18/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Wen-sen Hsieh 600 North Wolfe St. Baltimore, MD 21287

31. Date filed (Month, Day, Year)

DEC 23 1997

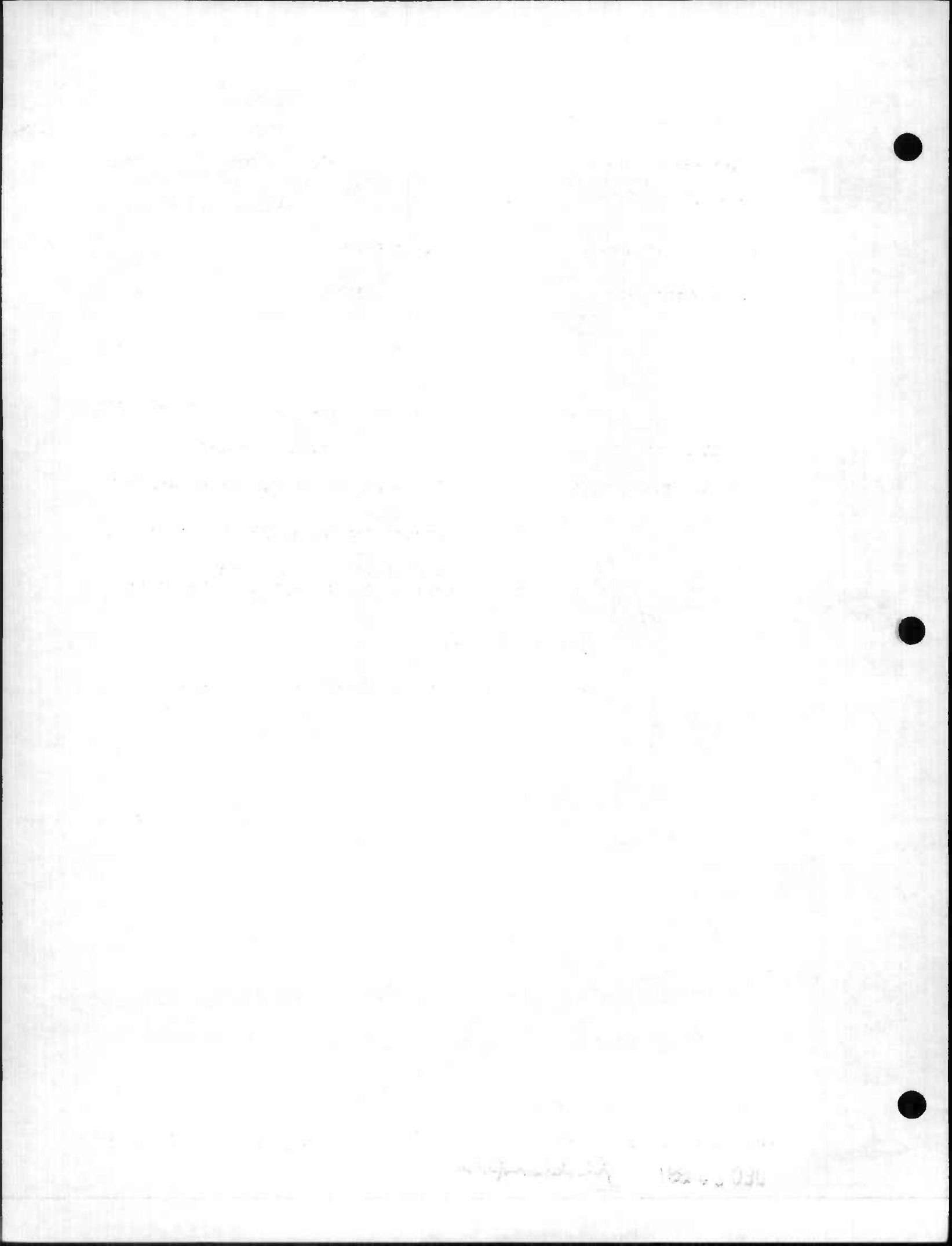
32. Registrar's Signature

John A. ...

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38714

| | | | | | | | | | | | |
|--|--|---|--|---|---|--|--|---|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) EVA | | | | 2. Date of Death Month DEC. Day 19, Year 1997 | | | | 3. Time of Death 11 AM | | |
| | 4a. Facility Name (If not institution, give street and number) LORIEN NURSING HOME | | | | 4b. City, Town, or Location of Death COLUMBIA | | | | 4c. County of Death HOWARD | | |
| Funeral Director | 5. Social Security Number 144-12-8788 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 88 Yrs. | | 8. Date of Birth (Month, Day, Year) AUG. 5, 1909 | | 9. Birthplace (State or Foreign Country) NEW YORK | | |
| | Usual Residence of Decedent | | | | | | | | | | |
| 10a. State MD | | 10b. County HOWARD | | 10c. City, Town or Location COLUMBIA | | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| 10e. Street and Number 5495 GREEN DORY LANE | | | | 10f. Zip Code 21044 | | | | 10g. Citizen of What Country? USA | | | |
| 11. Marital Status <input type="checkbox"/> Navar Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER | | | | 16b. Kind of Business/Industry OWN HOME | | | |
| 17. Father's Name (First, Middle, Last) SAMUEL REINGOLD | | | | 18. Mother's Name (First, Middle, Maiden Surname) ETHEL KRANIS | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) MRS. SHIRLEY AMSTER (DAUG.) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5495 GREEN DORY LANE COLUMBIA, MD 21044 | | | | | | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) COLUMBIA MEM. PARK | | Data 12/21/97 | | 20c. Location - City or Town, State COLUMBIA, MD | | | | | |
| 21. Signature of Funeral Service Licensee  | | | | 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN RD., PIKESVILLE, MD 21208 | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <div style="display: flex; justify-content: space-between;"> <div> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>a. <u>Dementia</u></p> <p>Due to (or as a consequence of):</p> <p>b. _____</p> <p>Due to (or as a consequence of):</p> <p>c. _____</p> <p>Due to (or as a consequence of):</p> <p>d. _____</p> </div> <div> <p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last</p> </div> </div> | | | | | | | | | | Approximate Interval Between Onset and Death 5 years | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | |
| | | | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | | |
| 29b. Signature and title of certifier  | | | | 29c. License number D20789 | | 29d. Date signed (Month, Day, Year) Dec 19, 1997 | | | | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) William Flowers MD 1055 Little Paxent Columbia MD | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 23 1997 | | | | 32. Registrar's Signature  | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38715

| | | | | | | | | | | | | |
|--|---|--|--|---|---|--|---|---|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Sophia Horwitz | | | | 2. Date of Death Month Dec Day 19 Year 1997 | | | | 3. Time of Death 11:12PM | | | |
| | 4a. Facility Name (If not institution, give street and number) Sinai Hospital | | | | 4b. City, Town, or Location of Death Baltimore | | | | 4c. County of Death N/A | | | |
| Funeral Director | 5. Social Security Number 440-44-5737 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 80 Yrs. | | 8. Date of Birth (Month, Day, Year) AUG. 24, 1917 | | 9. Birthplace (State or Foreign Country) OKLAHOMA | | | |
| | Usual Residence of Decedent | | | | 10a. State MD | | | | 10b. County BALTIMORE | | | |
| 10c. City, Town or Location BALTIMORE | | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 10e. Street and Number 209 SLADE AVENUE | | | | |
| 10f. Zip Code 21208 | | | | 10g. Citizen of What Country? USA | | | | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | | |
| 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) SALES | | | | 16b. Kind of Business/Industry RETAIL | | | | |
| 17. Father's Name (First, Middle, Last) MITCHELL RING | | | | 18. Mother's Name (First, Middle, Maiden Surname) BERTHA SCHIFF | | | | 19. Informant's Name/Relationship (Type, Print) IRVIN HORWITZ / SON | | | | |
| 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 28811 W. KING WILLIAM DR; FARMINGTON HILLS, MI 48331 | | | | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) EMANUEL HEBREW | | | | |
| 20c. Location - City or Town, State 12-22-1997 OKLAHOMA CITY, OK | | | | 21. Signature of Funeral Service Licensee Joel D. Jones | | | | 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN RD; PIKESVILLE, MD 21208 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Uremia Due to (or as a consequence of): chronic renal insufficiency Due to (or as a consequence of): coronary artery disease Due to (or as a consequence of): | | | | Approximate Interval Between Onset and Death 15 days 5 Yrs 13 Yrs | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | |
| 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day, Year) | | | | |
| 28b. Time of Injury M | | | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 28d. Describe how Injury occurred | | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | |
| 29b. Signature and title of certifier Danielle Pritchett MD | | | | 29c. License number AS2402321DP9287 | | | | 29d. Date signed (Month, Day, Year) Dec 19, 1997 | | | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Danielle D. Pritchett, MD. 2401 WEST BELVEDERE | | | | 31. Date filed (Month, Day, Year) DEC 23 1997 | | | | 32. Registrar's Signature John Davidson-Randall | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

State Registrar

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

To Be Completed by Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38716

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Clarence Harold Johnson

2. Date of Death

Month

Day

Year

3. Time of Death

11:38AM

4a. Facility Name (If not institution, give street and number)

Baltimore VA Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

212-26-6489

6. Sex

M ☒ F ☐

7. Age (In yrs. last birthday)

68

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Aug. 12, 1929

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

Maryland

10a. State

N/A

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes ☐ No

10a. Street and Number

808 E. Coldspring Lane

10f. Zip Code

21212

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☐ Married
☐ Widowed ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☒ Yes ☐ No Korean
If Yes, Give Year or Dates Conflict

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

Collage (1-4or 5+)

11th grade

16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

LABORER

16b. Kind of Business/Industry

Private Business

17. Father's Name (First, Middle, Last)

John Johnson

18. Mother's Name (First, Middle, Maiden Sumama)

Julia Ann Lightfoot

19a. Informant's Name/Relationship (Type, Print)

Julia Hall / Sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

832 E. Preston Street Baltimore, Md 21202

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Crimson Forest Veterans C.

Date

12/29/97

20c. Location - City or Town, State

Baltimore, Md

21. Signature of Funeral Service/Licenses

Debra Harris

22. Name and Address of Facility

CHATMAN - HARRIS F.H.
5240 REISTERSTOWN ROAD
BALTIMORE, MD 21215

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. aspiration pneumonia

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

3 Weeks

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

prostate cancer.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☒ Unknown

24a. Was an autopsy performed?

☒ Yes ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☒ Inpatient☐ ER/Outpatient☐ DOA

28. Place of Death (Check only one)

Other:

☐ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation
☐ Accident ☐ Could not be determined
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dr. M. P. P.

29c. License number

P09753

29d. Date signed (Month, Day, Year)

12/20/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hamang Patel 22 South Greene St. Baltimore, Md. 21201-1595.

31. Date filed (Month, Day, Year)

DEC 23 1997

32. Registrar's Signature

Julia Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

DEC 2 8 1931

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38717

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

WILLIAM

JONES

2. Date of Death

Month Day Year
DECEMBER 18, 1997

3. Time of Death

7:04 PM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Saint Joseph Medical Center

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

5. Social Security Number

219 32 6451

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

63 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Dec. 9, 1934

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Towson

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

806 Providence Rd.

10f. Zip Code

21286

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Supervisor

16b. Kind of Business/Industry

Banking

17. Father's Name (First, Middle, Last)

Elijah Riggs Jones

18. Mother's Name (First, Middle, Maiden Surname)

Charlotte Lycett

19a. Informant's Name/Relationship (Type, Print)

Peggy S. Jones / Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

806 Providence Rd., Baltimore, MD 21286

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Green Mount Crematory 12/20/97

Date

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

Stephen D. Lohrmann

22. Name and Address of Facility

CAFA Stephen D. Lohrmann P.A.
8717 Green Pastures Dr., Baltimore, MD 21286

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

MULTISYSTEM ORGAN FAILURE

Approximate Interval Between Onset and Death

2 WEEKS

a. Due to (or as a consequence of):
COLON PERFORATION

2 WEEKS

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CHRONIC OBSTRUCTIVE PULMONARY DISEASE

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Timothy Low, M.D.

29c. License number

D24034

29d. Date signed (Month, Day, Year)

12/18/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TIMOTHY LOW, M.D. 7620 YORK ROAD TOWSON, MARYLAND 21204

31. Date filed (Month, Day, Year)

DEC 23 1997

32. Registrar's Signature

Julia Davidson

State
Registrar

Baltimore, Maryland 21215-0020

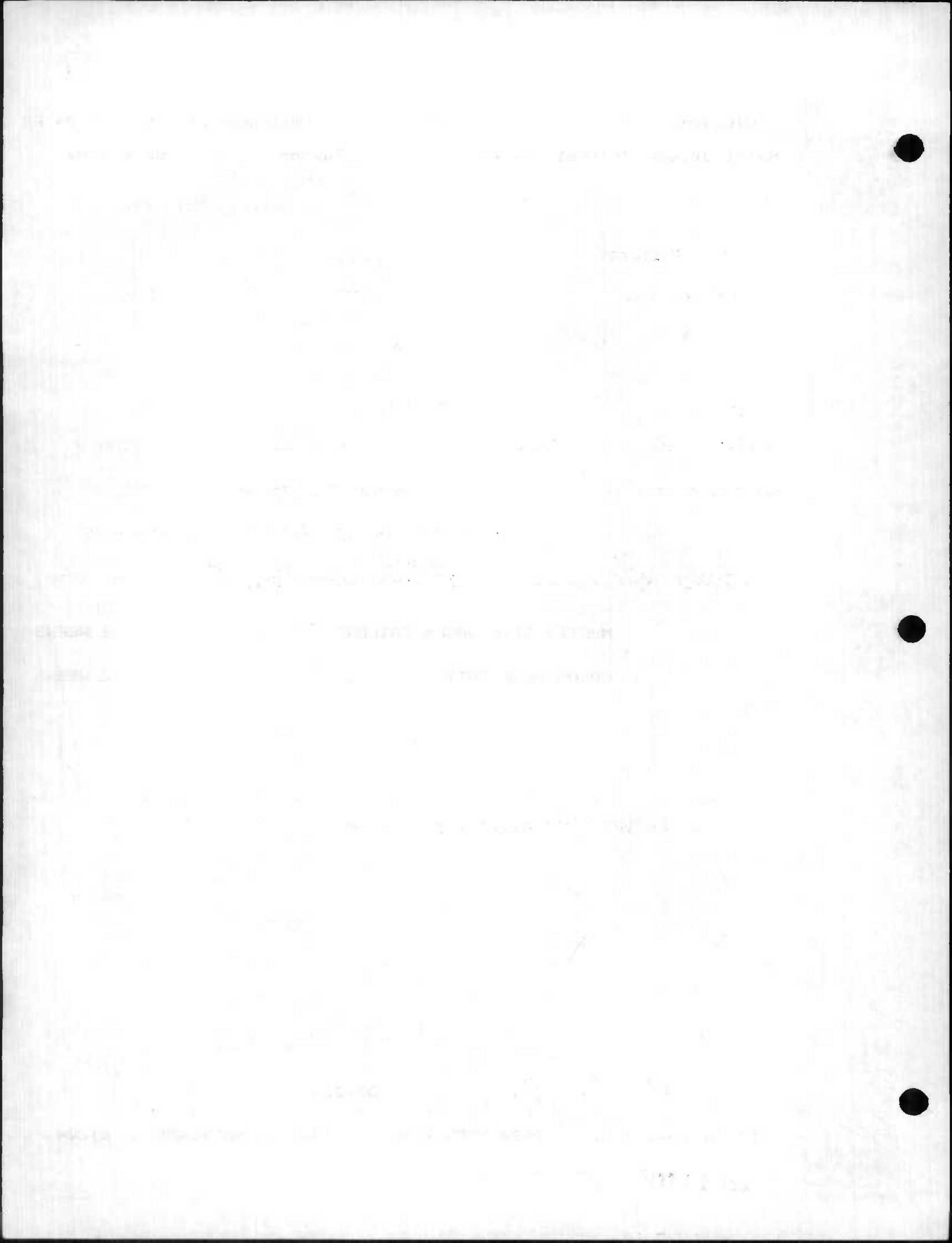
Division of Vital Records, P.O. Box 68760,

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be completed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38718

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Christopher Columbus Kelly

2. Date of Death

Month Day Year
December 18 1997

3. Time of Death

1615

Funeral
Director

4a. Facility Name (If not institution, give street and number)

University of Maryland Medical System

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

NA

5. Social Security Number

220-36-6283

6. Sex

M ☒ F

7. Age (In yrs. last birthday)

56

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Dec. 25, 1940

9. Birthplace (State or Foreign Country)

S.C.

Usual Residence of Decedent

10a. State

MD

10b. County

NA

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

1627 W. Lanvale St.

10f. Zip Code

21217

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married ☐ Married
3 ☐ Widowed ☐ Divorced

12. Was Decedent Ever In U.S.

Armed Forces?
1 ☐ Yes ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
10thCollege (1-4or 5+)
NA

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Self Employed

16b. Kind of Business/Industry

Junk yard

17. Father's Name (First, Middle, Last)

Wesley Kelly

18. Mother's Name (First, Middle, Maiden Summa)

Lois Lundegdale

19a. Informant's Name/Relationship (Type, Print)

Doris Kirkwood - Sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2401 Ailsa Ave Balto. Md 21214

20a. Method of Disposition

1 ☒ Burial ☐ Cremation ☐ Removal from State
4 ☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

King Memorial Park 12/24/97 Randallstown, MD

21. Signature of Funeral Service Licensee

Phyllis B. Starnes

22. Name and Address of Facility

March Funeral Home West
4300 Wabash Ave. Balto. Md 21215

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Disseminated Intravascular Coagulation

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Sepsis

Due to (or as a consequence of):

c. Pancreatitis

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Liver Failure

Hepatitis B

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes ☒ No25. Was case referred to medical examiner?
1 ☐ Yes ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural ☐ Pending investigation
2 ☐ Accident ☐ Suicide
3 ☐ Suicide ☐ Could not be determined
4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Stephen L. Lin, M.D.

29c. License number

P09748

29d. Date signed (Month, Day, Year)

12/18/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Stephen L. Lin, MD 22 S. Greene St. Baltimore, MD 21201

31. Date of Death (Month, Day, Year)

DEC 23 1997

32. Registrar's Signature

John P. ...

State
Registrar

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

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To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38719

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Kye Soon Kim

2. Date of Death

Dec 20 1997

Day

Year

3. Time of Death

10:40pm

4a. Facility Name (If not institution, give street and number)

10405 Petersboro Road

4b. City, Town, or Location of Death

Woodstock

4c. County of Death

Howard

Funeral
Director

5. Social Security Number

Unknown

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

84 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

OCT. 6, 1913

9. Birthplace (State or Foreign Country)

Korea

Usual Residence of Decedent

10a. State

Md.

10b. County

Howard

10c. City, Town or Location

Woodstock

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

10405 Petersboro Rd.

10f. Zip Code

21163

10g. Citizen of What Country?

Korea

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Oriental

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

6

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Domestic

17. Father's Name (First, Middle, Last)

Kyung Ho Kim

18. Mother's Name (First, Middle, Maiden Surname)

Si Oh

19a. Informant's Name/Relationship (Type, Print)

Matthew Ban - son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10405 Petersboro Rd., Woodstock, Md. 21163

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Meadowridge Mem. Pk.

Date

12/23/97

20c. Location - City or Town, State

Elkridge, Md.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Gary L. Kaufman Funeral Home at Meadowridge MP
7250 Washington Blvd., Elkridge, Md. 21075

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Senile Dementia

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

3 years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D52544

29d. Date signed (Month, Day, Year)

Dec 21, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Benjamin S. Lee, M.D. 500 N. Rolling Rd., Suite 4, Catonsville, MD 21228

31. Date filed (Month, Day, Year)

DEC 23 1997

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

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Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 38720

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last) Lawrence Otto Koch
2. Date of Death Month December Day 19 Year 1997
3. Time of Death 4:54 PM

Funeral
Director

4a. Facility Name (If not Institution, give street and number) Greater Baltimore Medical Center
4b. City, Town, or Location of Death Towson
4c. County of Death Baltimore

5. Social Security Number 218-36-1896
6. Sex 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday) 57 Yrs.
8. Date of Birth (Month, Day, Year) June 13, 1940
9. Birthplace (State or Foreign Country) Maryland

Usual Residence of Decedent
10a. State Maryland
10b. County Baltimore
10c. City, Town or Location Middle River
10d. Inside City Limits 1 ☐ Yes 2 ☒ No

10e. Street and Number 49 Coll Breeze Drive
10f. Zip Code 21220
10g. Citizen of What Country? United States

11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 Years College (1-4 or 5+) Mechanical Engineer
16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Mechanical Engineer
16b. Kind of Business/Industry Baltimore County

17. Father's Name (First, Middle, Last) Charles Louis Koch
18. Mother's Name (First, Middle, Maiden Surname) Hilda Mae Cole

19a. Informant's Name/Relationship (Type, Print) Janet M. King/Sister
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 49 Cool Breeze Drive Baltimore, Maryland 21220

20a. Method of Disposition ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place) Gardens of Faith Cem. 12/23/97
20c. Location - City or Town, State Rossville, MD

21. Signature of Funeral Service Licensee
22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death) e. CARDIOMYOPATHY
Due to (or as a consequence of):
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown
24a. Were an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one) Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier Malah O. [Signature]
29c. License number D04193
29d. Date signed (Month, Day, Year) 20 Dec 97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GRMC 6701 N-CHARLES ST. BALTIMORE MD 21204

31. Date filed (Month, Day, Year) DEC 23 1997
32. Registrar's Signature John Davidson-Randall

State
Registrar

Koch, Lawrence
Baltimore, Maryland 21215-0020
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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,
PT # 300345722

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38721

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Anna Kapp

2. Date of Death

December 18 1997

3. Time of Death

530PM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Johns Hopkins Geriatric Center

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Baltimore City

5. Social Security Number

219-01-9782

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

76 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

10-21-19

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

511 S. PATTERSON PARK AVENUE

10f. Zip Code

21231

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
10 YEARS

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

LINE WORKER

16b. Kind of Business/Industry

CROSSE & BLACKWELL

17. Father's Name (First, Middle, Last)

JOSEPH HIMMEL

18. Mother's Name (First, Middle, Maiden Surname)

ELIZABETH BARNES

19a. Informant's Name/Relationship (Type, Print)

MS. LEONA KAPP 511 S. PATTERSON PARK AVE. BALTO 21231

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

OAK LAWN CEM.

Date

12-22

20c. Location - City or Town, State

BALTO. MD.

21. Signature of Funeral Service Licensee

Charles R. Kaczorowski

22. Name and Address of Facility

KACZOROWSKI FUNERAL HOME

1201 DUNDALK AVE. BALTO. MD. 21222

23a. Part I. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Clostridia difficile colitis

Due to (or as a consequence of):

days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. End stage COPD

Due to (or as a consequence of):

years

c. Congestive heart failure

Due to (or as a consequence of):

months

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Cor pulmonale, renal failure, anemia
atrial fibrillation, malnutrition
respiratory failure on ventilator

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home5 ☐ Residence8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical ExaminerTo the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

W.B. Coe

29c. License number

D04383

29d. Date signed (Month, Day, Year)

12/22/97

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

W.B. Coe

5505 Hopkins Bayview Circle
BALTO MD 21224

31. Date filed (Month, Day, Year)

DEC 23 1997

32. Registrar's Signature

Julia Anderson

State
Registrar

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the funeral-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38722

| | | | | | | | | |
|---|---|---|--|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Mary A. Klemkowski | | | | 2. Date of Death Month Dec. Day 21 Year 1997 | | 3. Time of Death 3:45am | |
| | 4a. Facility Name (If not institution, give street and number) 1240 Hull Street | | | | 4b. City, Town, or Location of Death Baltimore City | | 4c. County of Death N/A | |
| Funeral Director | 5. Social Security Number 214-24-7186 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 67 Yrs. | | 8. Date of Birth (Month, Day, Year) April 19, 1930 | |
| | 10a. State MD | | 10b. County N/A | | 10c. City, Town or Location Baltimore City | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10e. Street and Number 1240 Hull Street | | | | 10f. Zip Code 21230 | | 10g. Citizen of What Country? United States | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8th Grade College (1-4 or 5+) N/A | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker | | 16b. Kind of Business/Industry Own Home | | |
| 17. Father's Name (First, Middle, Last) Charles Laucht | | | | 18. Mother's Name (First, Middle, Maiden Surname) Mary Ann Kirby | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Melvin P. Klemkowski/Husband | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1230 Hull Street, Baltimore Maryland 21230 | | | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Green Mount Cem. December 23, 1997 | | 20c. Location - City or Town, State Baltimore City | | | | |
| 21. Signature of Funeral Service Licensee Victor R. Doda, Jr. | | | | 22. Name and Address of Facility Charles L. Stevens Funeral Home, Inc. 1501 East Fort Avenue, Baltimore Maryland 21230 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. METASTATIC BREAST CANCER Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred |
| | | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier [Signature] | | 29c. License number 518320 | | 29d. Date signed (Month, Day, Year) 12/23/97 | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) John F. [Signature] - Johns Hopkins Oncology Center 600 N. Wolfe St. Baltimore 21287. | | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 23 1997 | | 32. Registrar's Signature [Signature] | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Item 23 part I 27, 28a-f 12-29-97 rja

Certificate of Death

Reg. No.

97 38723

DIANE
KENMIRPhysician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

Diane Marie Kenmir

2. Date of Death
Month Day Year
DECEMBER 10, 19973. Time of Death
6:20P.M.

4a. Facility Name (If not institution, give street and number)

511 EASTVIEW TERRACE, Apt. 3

4b. City, Town, or Location of Death

ABINGDON

4c. County of Death

HARFORD COUNTY

5. Social Security Number

503-02-2299

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

28 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

June 9, 1969

9. Birthplace (State or Foreign Country)

Washington

Usual Residence of Decedent

10a. State

Maryland

10b. County

Harford

10c. City, Town or Location

Abingdon

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

511 East View Terrace, Apt. 3

10f. Zip Code

21009

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

2

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Cake Decorator

16b. Kind of Business/Industry

Bakery Retail

17. Father's Name (First, Middle, Last)

Patrick Lawrence Kenmir

18. Mother's Name (First, Middle, Maiden Surname)

Majorie (UNK) Brown

19a. Informant's Name/Relationship (Type, Print)

David M. Tomaszewski/Friend

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

38 Amber Drive, Delta, Pennsylvania 17314

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Hilltop Crematory

Date

12-16-97

20c. Location - City or Town, State

Towson, Maryland

21. Signature of Funeral Service Licensee

Charles A. Emge Jr.

22. Name and Address of Facility

Howard K. McComas III Funeral Home, P.A.

1317 Cokesbury Rd., Abingdon, Maryland 21009

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

MIXED DRUG INTOXICATION

e. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☒ Suicide 4 ☐ Homicide 5 ☒ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

12-10-97

28b. Time of Injury

4:35 PM

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how Injury occurred

SUBJECT TOOK DRUGS

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

FOUND AT HOME

28f. Location (Street and Number or Rural Route Number, City or Town, State)

ABINGDON, MARYLAND

513 Eastview Terrace #3

29a. Certifier
(Check only one)1 ☐ Certifying Physician2 ☒ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dennis J. Chute

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

DECEMBER 11, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

State
Registrar

31. Date filed (Month, Day, Year)

DEC 23 1997

32. Registrar's Signature

Julia Davidson-Randall

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Item: 17, per F.H. G-755 1/26/98 reb

Certificate of Death

Reg. No.

97 38724

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

JAMES LUTHER.

2. Date of Death

Month Day Year
DECEMBER 21 1997

3. Time of Death

6:15 AM

4a. Facility Name (If not institution, give street and number)

Liberty Medical Center

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

240-38-2994

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

67 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year
8 30 30

9. Birthplace (State or Foreign Country)

North Carolina

Usual Residence of Decedent

10a. State
MD

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3207 Piedmont Ave

10f. Zip Code

21216

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Mechanic

16b. Kind of Business/Industry

B.F.I INC.

17. Father's Name (First, Middle, Last)

James Garfield Gunther

GARFIELD LUTHER

18. Mother's Name (First, Middle, Maiden Surname)

Mattie Graves

19a. Informant's Name/Relationship (Type, Print)

Ms. Vendetta Luther (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4022 Hanson Oaks Drive Landover, Md. 20784

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Loudon Park Cem.

Date

12/27/97 Baltimore, Md.

21. Signature of Funeral Service Licensee

Joseph L. Russ

22. Name and Address of Facility

Joseph L. Russ
2222 W. North Ave, Balto. Md. 21216

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CIRROHOSIS OF LIVER

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

RENAL FAILURE

HYPERKAELEMIA

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

Other:

4 ☐ Nursing Home

5 ☐ Residence

6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and Title of certifier

Joseph L. Russ

HOUSE PHYSICIAN

29c. License number

D42723

29d. Date signed (Month, Day, Year)

DECEMBER 21 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AVVERAITALI M

HARISH.

3745 FOXFORD BALTIMORE

STREAM ROAD MD 21236

31. Date filed (Month, Day, Year)

DEC 23 1997

32. Signature

Julia Davidson-Rendell

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38725

| | | | | | | | | | |
|---|---|--|---|---|--|--|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Elisha Lockett | | | | 2. Date of Death Month December Day 19 Year 1997 | | 3. Time of Death 4:05 AM | | |
| | 4a. Facility Name (If not institution, give street and number) Sinai Hospital of Baltimore | | | | 4b. City, Town, or Location of Death Baltimore | | 4c. County of Death Baltimore | | |
| Funeral Director | 5. Social Security Number 235-05-7147 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 82 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) 7-11-1915 | 9. Birthplace (State or Foreign Country) La | |
| | Usual Residence of Decedent | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State MD | | 10b. County NA | | 10c. City, Town or Location Baltimore | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| | 10e. Street and Number 2537 Loyola Northway | | | | 10f. Zip Code 21215 | | 10g. Citizen of What Country? U.S.A | | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Black | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11th grade College (1-4 or 5+) NA | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Research | | | 16b. Kind of Business/Industry W. R. Grace Company | | | |
| | 17. Father's Name (First, Middle, Last) Willis Lockett | | | | 18. Mother's Name (First, Middle, Maiden Surname) Sallie Twitty | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) Alberta Lockett - wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2537 Loyola Northway Balt, MD 21215 | | | | |
| | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Woodlawn Cemetery | | Date 12-24-97 | | 20c. Location - City or Town, State Baltimore, MD | | |
| | 21. Signature of Funeral Service Licensee Blair W. W... | | | | 22. Name and Address of Facility March F. H. West 4300 Wabash Avenue Balt, MD 21215 | | | | |
| | 23a. Pertinent diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. subdural hematoma Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | | | | | | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | |
| 29b. Signature and title of certifier Priscilla Cheng MD | | | | 29c. License number AS24-02321-PC-9518 | | 29d. Date signed (Month, Day, Year) December 19, 1997 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Priscilla Cheng, MD, Sinai Hospital of Baltimore | | | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 23 1997 | | | | 32. Registrar's Signature Julian Davidson-Rodriguez | | | | | |

Baltimore, Maryland 21215-0020

permitted. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

CIP

JOHN LEE

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Item: 23a part I per MEO G-755 1/17/98 dh reg
 Items: 23 part I, 27, 28a-f per MEO G-755 1/2/98 **Certificate of Death**

Reg. No.

97 38726

| | | | | | | | | | | |
|--|---|------------------------------|---|--|--|-------------------------|---|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) John H. Lee | | | | 2. Date of Death Month Day Year DECEMBER 18, 1997 | | | | 3. Time of Death 11:57PM | |
| | 4a. Facility Name (If not institution, give street and number) HOWARD COUNTY GENERAL HOSPITAL | | | | 4b. City, Town, or Location of Death COLUMBIA | | | | 4c. County of Death HOWARD | |
| Funeral Director | 5. Social Security Number 168-56-9432 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (in yrs. last birthday) 27 Yrs. | | 8. Date of Birth (Month, Day, Year) APR. 28, 1970 | | 9. Birthplace (State or Foreign Country) Pennsylvania | |
| | Usual Residence of Decedent | | | | | | | | | |
| 10a. State Md. | | 10b. County Howard | | 10c. City, Town or Location Ellicott City | | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 10e. Street and Number 10158 Bracken Dr. | | | | 10f. Zip Code 21042 | | | | 10g. Citizen of What Country? USA | | |
| 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: Oriental | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 5+ College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Lawyer | | | | 16b. Kind of Business/Industry Legal | | |
| 17. Father's Name (First, Middle, Last) Chin Pil Lee | | | | | 18. Mother's Name (First, Middle, Maiden Surname) Hwa Ja Hahm | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Chin Pil Lee - father | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10158 Bracken Drive, Ellicott City, Md. 21042 | | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Meadowridge Memorial Pk. | | | Date 12/21/97 | | 20c. Location - City or Town, State Elkridge, Md. | | |
| 21. Signature of Funeral Service Licensee | | | | | 22. Name and Address of Facility Gary L. Kaufman Funeral Home at Meadowridge MP 7250 Washington Blvd., Elkridge, Md. 21075 | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. ACUTE NARCOTIC INTOXICATION COMPLICATED BY ASTHMA Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | | | | | | |
| 24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Could not be determined | | | 28a. Date of Injury (Month, Day, Year) Unknown | | 28b. Time of Injury Unknown M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred Unknown | |
| | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Found at home | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) 10158 Bracken Drive Columbia, Md. | | | |
| 29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | |
| 29b. Signature and title of certifier | | | | | 29c. License number O.C.M.E. | | | 29d. Date signed (Month, Day, Year) DECEMBER 19, 1997 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dennis J. Chute, 11 Penn Street, Baltimore, Maryland 21201 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 23 1997 | | | 32. Registrar's Signature | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
 Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

[Faint, illegible handwritten text covering the majority of the page]

[Faint handwritten signature or name]

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38727

| | | | | | | | | | |
|--|--|---|--|--|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Stephanie Lewis | | | | 2. Date of Death Month December Day 21 Year 1997 | | 3. Time of Death 01:55 am | | |
| | 4a. Facility Name (If not institution, give street and number) University of Maryland Medical Center | | | | 4b. City, Town, or Location of Death Baltimore | | 4c. County of Death N/A | | |
| Funeral Director | 5. Social Security Number 230-11-5477 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 26 Yrs. | | 8. Date of Birth (Month, Day, Year) May 25, 1971 | | |
| | 9. Birthplace (State or Foreign Country) Va. | | 10a. State Md. | | 10b. County Prince George | | 10c. City, Town or Location Beltsville | | |
| Usual Residence of Decedent | | 10d. Inade City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number 3586 Powder Mill Rd. | | 10f. Zip Code 20705 | | 10g. Citizen of What Country? U.S.A | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Black | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 4 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Manager | | 16b. Kind of Business/Industry Linen | | | | | |
| 17. Father's Name (First, Middle, Last) Benjamin Gilbert Sr. | | | | 18. Mother's Name (First, Middle, Maiden Surname) Ollie Slayton | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Anthony Lewis husband | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3586 Powder Mill Rd. Beltsville, Md. 20705 | | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Church Cemetery | | 20c. Location - City or Town, State 12-26-97 Long Island, Va. | | | | | |
| 21. Signature of Funeral Service Licensee Carlton C. Douglas | | | | 22. Name and Address of Facility Douglas Funeral Service 1704 McCulloch St. Balto. Md. 21217 | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. cerebral herniation Due to (or as a consequence of): b. subarachnoid hemorrhage Due to (or as a consequence of): c. disseminated intravascular coagulation Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death 12 hours 24 hours 24 hours | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | |
| | | | | | | | | 24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA | | 26. Place of Death (Check only one) Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier Barbara E. Lazio MD | | 29c. License number P10036 | | 29d. Date signed (Month, Day, Year) December 21, 1997 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Barbara E. Lazio, MD, 22 S. Greene St., Baltimore, MD 21201 | | | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 23 1997 | | 32. Registrar's Signature Julia Davidson-Rodell | | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

Division of Vital Records, P.O. Box 68760,

State
Registrar

Handwritten notes at the top left, possibly including a date or reference number.

Handwritten text at the top right, possibly a title or header.

Main body of handwritten text, appearing to be a list or series of entries, possibly related to a survey or inventory.

Lower section of handwritten text, continuing the list or providing additional details, possibly including a signature or date at the bottom.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38728

Physician
/Medical
Examiner

Funeral
Director

| | | | | | | | |
|--|--|---|--|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last) Norma Lough | | | | 2. Date of Death Month Day Year DECEMBER 18 1997 | | 3. Time of Death 15:32 | |
| 4a. Facility Name (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL | | | | 4b. City, Town, or Location of Death BALTIMORE CITY | | 4c. County of Death N/A | |
| 5. Social Security Number 218-14-7333 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 72 Yrs. | | 8. Date of Birth (Month, Day, Year) Dec. 24, 1924 | |
| 9. Birthplace (State or Foreign Country) Maryland | | | | | | | |
| Usual Residence of Decedent | | | | | | | |
| 10a. State Maryland | | 10b. County Baltimore | | 10c. City, Town or Location Perry Hall | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10e. Street and Number 9118 Snyder Lane | | | | 10f. Zip Code 21128 | | 10g. Citizen of What Country? U.S.A. | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed) 12th grade | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker | | 16b. Kind of Business/Industry Own Home | |
| 17. Father's Name (First, Middle, Last) Adam Jackowiak | | | | 18. Mother's Name (First, Middle, Maiden Surname) Catherine M. Reagan | | | |
| 19a. Informant's Name/Relationship (Type, Print) Mr. William C. Lough (spouse) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9118 Snyder Lane, Perry Hall, MD 21128 | | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Green Mount Crematory | | 20c. Date 12/22/97 | | 20d. Location - City or Town, State Baltimore, Maryland | |
| 21. Signature of Funeral Service Licensee  | | | | 22. Name and Address of Facility Schimunek Funeral Homes, Inc. 9705 Belair Rd., Baltimore, MD 21236 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Sepsis Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | Approximate Interval Between Onset and Death 2 weeks |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |
| | | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | | 28d. Describe how injury occurred | | | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| 29b. Signature and title of certifier  | | 29c. License number RES-000 | | 29d. Date signed (Month, Day, Year) December 18, 1997 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Eric Jackson 600 north wolf street Baltimore, MD 21287-9106 | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 23 1997 | | 32. Registrar's Signature  | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38729

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Daniel Leary

2. Date of Death

December 20 1997 12:57 pm

3. Time of Death

Funeral
Director

4a. Facility Name (If not institution, give street and number)

JOHN HOPKINS MEDICAL CENTER Baltimore

4b. City, Town, or Location of Death

4c. County of Death

Baltimore City

5. Social Security Number

170-01-0515

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

80 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

August 3, 1917

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Odenton

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

544 Maple Ridge Lane

10f. Zip Code

21113

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: WWII Korea

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Military & Civil Servant

16b. Kind of Business/Industry

U.S. Government

17. Father's Name (First, Middle, Last)

Frank Leary

18. Mother's Name (First, Middle, Maiden Surname)

Anna Roach

19a. Informant's Name/Relationship (Type, Print)

Margaret Julia Leary - Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

544 Maple Ridge Lane, Odenton, MD 21113

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Arlington Nat'l Cemetery 12/31

Date

20c. Location - City or Town, State

Arlington, Virginia

21. Signature of Funeral Service Licensee

▶ Patrick J. Arnold Jr.

22. Name and Address of Facility

Hardesty funeral Home, P.A.
12 Ridgely Avenue, Annapolis, MD 21401

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

Cardio pulmonary arrest

2 hours

Due to (or as a consequence of):

b.

Coronary ARTERY DISEASE

years

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to Immediate Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

▶ Randolph B. Capone

29c. License number

RES - 000

29d. Date signed (Month, Day, Year)

DECEMBER 20, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

RANDOLPH CAPONE, MD. THE JHH, 600 N WOLFE ST., BALTIMORE, MD. 21287

31. Date filed (Month, Day, Year)

DEC 23 1997

32. Registrar's Signature

Julia Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be submitted within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 88760

To the Hospital or Attending Physician: The law requires that the death certificate be submitted within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Item#18 per FH G754 12/23/97 EW

97 38730

| | | | | | |
|---|---|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) NATHAN LEVIN | | 2. Date of Death Month DEC. Day 18 Year 1997 | | 3. Time of Death 6:20 AM |
| | 4a. Facility Name (If not institution, give street and number) NORTH OAKS NURSING HOME | | 4b. City, Town, or Location of Death BALTIMORE | | 4c. County of Death BALTIMORE |
| Funeral Director | 5. Social Security Number 219-18-2340 | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 98 Yrs. | If Under 1 Year Months 0 Days 0 | If Under 24 Hrs. Hours 0 Min. 0 |
| | 8. Date of Birth (Month, Day, Year) DEC. 28, 1898 | | 9. Birthplace (State or Foreign Country) MARYLAND | | |
| To Be Completed by Funeral Director | Usual Residence of Decedent | | | | |
| | 10a. State MD | 10b. County BALTIMORE | 10c. City, Town or Location BALTIMORE | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| | 10e. Street and Number 725 MT. WILSON LA., APT. 225 | | 10f. Zip Code 21208 | | 10g. Citizen of What Country? USA |
| | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
| | 14. Race - American Indian, Black, White, etc. Specify: WHITE | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9 College (1-4 or 5+) College | | |
| | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) INVESTOR | | 16b. Kind of Business/Industry REAL ESTATE | | |
| | 17. Father's Name (First, Middle, Last) LOUIS LEVIN | | 18. Mother's Name (First, Middle, Maiden Surname) RACHEL Mary Goldberg GOLDBERG | | |
| | 19a. Informant's Name/Relationship (Type, Print) DR. HOWARD LEVIN (SON) | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 538 MONTGOMERY SCHOOL LA WYNNEWOOD, PA 19096 | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) ANSHE EMUNAH-AITZ CHAIM | | 20c. Location - City or Town, State 12/21/97 BALTO., MD |
| | 21. Signature of Funeral Service Licensee  | | 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN RD., PIKESVILLE, MD 21208 | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | |
| Physician /Medical Examiner | Immediate Cause (Final disease or condition resulting in death) | | a. Renal Failure | | Approximate Interval Between Onset and Death 2 wks |
| | Due to (or as a consequence of): | | b. Cognitive Heart Failure | | 5 yrs |
| | Due to (or as a consequence of): | | c. | | |
| | Due to (or as a consequence of): | | d. | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | |
| | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | |
| | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | |
| | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | |
| | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of injury (Month, Day, Year) | | 28b. Time of Injury M |
| 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29e. Certifier (Check only) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | |
| 29b. Signature and title of certifier  MD | | 29c. License number D38675 | | 29d. Date signed (Month, Day, Year) 12/19/97 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOEL MESHULAM 1147 SHANOVER ST BALTIMORE MD 21230 | | | | | |
| State Registrar | 31. Date filed (Month, Day, Year) DEC 23 1997 | | 32. Registrar's Signature  | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38731

Physician
/Medical
Examiner

Funeral
Director

1. Decedent's Name (First, Middle, Last)

Bernice Delores Lee

2. Date of Death

Month Day Year
12 19 1997

3. Time of Death

11:50 a.m.

4a. Facility Name (If not institution, give street and number)

7859 Crilley Road

4b. City, Town, or Location of Death

Glen Burnie

4c. County of Death

Anne Arundel Co.

5. Social Security Number

213-26-6769

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

65 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

02 16 1932

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel Co.

10c. City, Town or Location

Glen Burnie

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7859 Crilley Road Apt 414

10f. Zip Code

21061

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

11th

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Factory Worker

16b. Kind of Business/Industry

Glass Company

17. Father's Name (First, Middle, Last)

Allen Coates

18. Mother's Name (First, Middle, Maiden Surname)

Ruth Griffin

19a. Informant's Name/Relationship (Type, Print)

Elinda Lee/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5482 C-1 Cedar Lane, Columbia, Maryland 21044

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Cedar Hill Cemetery

Date

12/23

20c. Location - City or Town, State

Brooklyn Park, Md.

21. Signature of Funeral Service Licensee

Handwritten signature

22. Name and Address of Facility

William C. Brown Community Funeral Home

1206 W. North Avenue, Baltimore, Maryland 21217

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. MYOCARDIAL INFARCTION

Due to (or as a consequence of):

b. RENAL FAILURE

Due to (or as a consequence of):

c. HYPERTENSION

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Handwritten signature

29c. License number

D23530

29d. Date signed (Month, Day, Year)

12-22-97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3927 ANNAPOLIS ROAD 21227

31. Date filed (Month, Day, Year)

DEC 23 1997

32. Registrar's Signature

Handwritten signature

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

FOR THE FUTURE
BANK OF AMERICA

12-22-50

12-22-50

12-22-50

12-22-50

12-22-50

DEC 22 1950

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 38732

| | | | | | | | | |
|---|---|---|---|---|--|--------------------------------|---|---|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) ROBERT L. LOFTIN | | | | 2. Date of Death Month DEC. Day 16 Year 1997 | | 3. Time of Death 1:45 A.M. | |
| | 4a. Facility Name (If not institution, give street and number) BALTIMORE VETERANS ADMINISTRATION HOSPITAL | | | | 4b. City, Town, or Location of Death BALTIMORE | | 4c. County of Death N/A | |
| Funeral Director | 5. Social Security Number 237 24 1969 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 76 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) MAR. 12, 1921 | 9. Birthplace (State or Foreign Country) North Carolina |
| | Usual Residence of Decedent | | | | 10c. City, Town or Location BALTIMORE | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| To Be Completed by Funeral Director | 10e. State MD. | | 10b. County N/A | | 10f. Zip Code 21215 | | 10g. Citizen of What Country? U.S. OF A. | |
| | 10f. Street and Number 5116 QUEENSBERRY AVENUE | | 10g. Citizen of What Country? U.S. OF A. | | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No 12/31/42 If Yes, Give Year or Dates: 12/14/45 | |
| | 13. Was Decedent of Hispanic Origin? (Specify Yes or No) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: BLACK | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) N/A College (1-4 or 5+) N/A | | 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HANDYMAN | |
| | 16. Kind of Business/Industry CONSTRUCTION | | 17. Father's Name (First, Middle, Last) ELIJAH LOFTIN | | 18. Mother's Name (First, Middle, Maiden Surname) JULIA SMITH | | 19a. Informant's Name/Relationship (Type, Print) ALVIN J. GWYNN (STEP SON) | |
| | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2401 CHELSEA TERRACE BALTO., MD. 21216 | | 20e. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) 12/23/97 GARRISON FOREST VET. CEM. | | 20c. Location - City or Town, State BALTO. OWINGS MILLS, MD. Co. | |
| | 21. Signature of Funeral Service Licensee <i>Lewis T. Gwynn</i> | | 22. Name and Address of Facility LEWIS T. GWYNN FUNERAL HOME 21215-6393 4517 PARK HEIGHTS AVE. BALTO., MD. | | 23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. RESPIRATORY FAILURE Due to (or as a consequence of): A DENO CARCINOMA Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): | | Approximate Interval Between Onset and Death 2 weeks 2 weeks | |
| | 23e. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | |
| | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | |
| | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier <i>Hamang Patel</i> | | 29c. License number P09753 | | 29d. Date signed (Month, Day, Year) 12/16/97 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hamang Patel 10 North Greene St. Baltimore, md. 21201-1524 | | 31. Date filed (Month, Day, Year) DEC 23 1997 | | 32. Registrar's Signature <i>John Davidson-Randall</i> | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

CARRIE ROBERTS MOORE

2. Date of Death
Month Day Year

12 - 21 - 97

3. Time of Death

12:25 PM

4a. Facility Name (If not institution, give street and number)

Keswick Nursing Home

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

5. Social Security Number

411-05-6415

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

99 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

April 24, 1898

9. Birthplace (State or Foreign Country)

S.C.

Usual Residence of Decedent

10a. State

Md

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3300 Hillen Road

10f. Zip Code

21218

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year of Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
4th grade

College (1-4 or 5+)

NA

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Domestic

16b. Kind of Business/Industry

Private Homes

17. Father's Name (First, Middle, Last)

Walter H. McCullough

18. Mother's Name (First, Middle, Maiden Surname)

Phyllis Long

19a. Informant's Name/Relationship (Type, Print)

Carol E. Haysbert / daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3300 Hillen Road Baltimore Md 21218

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Knoxville National

Date

12-29-97

20c. Location - City or Town, State

Knoxville, Tenn

21. Signature of Funeral Service Licensee

Gabrielle Cook

22. Name and Address of Facility

William E. March F/H West
4300 Wabash Ave, Baltimore, Md 21215

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cerebrovascular Accident

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

72 hrs

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Hypertension

Due to (or as a consequence of):

20 yrs

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ALLERGIES INSECT

Chronic Arterial Fibrillation

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accidental 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Charles Johnson, MD

29c. License number

J1234

29d. Date signed (Month, Day, Year)

December 22, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Charles Johnson, MD, Keswick 700 W. 40th St Baltimore, MD 21211

31. Date filed (Month, Day, Year)

DEC 23 1997

Registrar's Signature

John Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

HELEN WEBSTER MURRAY

2. Date of Death

Month Day Year
DECEMBER 18, 1997

3. Time of Death

5:35 PM

4a. Facility Name (If not institution, give street and number)

Saint Joseph Medical Center

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

219-16-7713

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

76 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year
April 7 1921

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Parkville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8609 Midi Ave.

10f. Zip Code

21234

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12 yrs

College (1-4 or 5+)

16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

School crossing guard

16b. Kind of Business/Industry

Baltimore County Police Department

17. Father's Name (First, Middle, Last)

John E. Webster Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Mary C. Flaherty

19a. Informant's Name/Relationship (Type, Print)

Deland Murray

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8609 Midi Ave. Parkville, Maryland 21234

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

St. Mary's Cemetery

Date

Dec 22 1997

20c. Location - City or Town, State

Pylesville Maryland

21. Signature of Funeral Service Licensee

Krista S. Wells

22. Name and Address of Facility

Evans Funeral Chapel
8800 Harford Rd Baltimore, Md 21234

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

CARDIOPULMONARY ARREST

Approximate interval Between Onset and Death

MINUTES

e.

Due to (or as a consequence of):

PNEUMONIA, COMMUNITY ACQUIRED

6 DAYS

b.

Due to (or as a consequence of):

METASTATIC CARCINOMA, HEPATIC

8 MONTHS

c.

Due to (or as a consequence of):

DIABETES MELLITUS INSULIN DEPENDENT

26 YEARS

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Wm. Carl Ebeling MD

29c. License number

D04577

29d. Date signed (Month, Day, Year)

12/17/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

WILLIAM CARL EBELING, M.D., 7401 OSLER DRIVE, TOWSON, MARYLAND 21204

31. Date filed (Month, Day, Year)

DEC 23 1997

32. Registrar's Signature

Julia Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 23a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38735

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Matthew McNair

2. Date of Death

December 6 1997

3. Time of Death

10:20 A.M.

4a. Facility Name (If not institution, give street and number)

UNIVERSITY HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

244-68-1159

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

55 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

4/7/42

9. Birthplace (State or Foreign Country)

NORTH CAROLINA

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1918 E. 30th STREET

10f. Zip Code

21218

10g. Citizen of What Country?

U.S.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: BLACK

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12College (1-4 or 5+)
-0-16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

CARPENTER

16b. Kind of Business/Industry

CONSTRUCTION

17. Father's Name (First, Middle, Last)

WESLEY MCNAIR, SR.

18. Mother's Name (First, Middle, Maiden Surname)

MAGNOLIA WHITTAKER

19a. Informant's Name/Relationship (Type, Print)

CLARA MCNAIR (WIFE)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1918 E. 30th STREET-BALTIMORE, MD 21218

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☒ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

ELIZABETH CHURCH CEM. 12/13/97 WHITE OAK, NC

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Dunbar L. Redd

22. Name and Address of Facility

REDD FUNERAL SERVICES

1721-27 N. MONROE ST.-BALTO., MD 21217

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)a. Fungal Meningitis
Due to (or as a consequence of):Approximate
Interval Between
Onset and Death

5 days

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

AIDS

Prostate Cancer

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☒ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury at
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Jonathan A. Turoff, M.D., Neurologist

29c. License number

AU417643579370

29d. Date signed (Month, Day, Year)

December 6 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jonathan A. Turoff, M.D., Dept. of Neurology, 225 Green St., Baltimore, MD.

31. Date (Month, Day, Year)

DEC 23 1997

32. Registrar's Signature
John Davidson-HendersonState
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
202-696-2000.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

2012

Project Summary

Project Summary
2012

x
x
x
x

Project Summary
2012

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38736

| | | | | | | | | | | | | | | | | | | | | |
|---|--|---|---|---|--|--|---|--|---|----|-----------------------|--|----|-------------------------------|--------------|----|------------------------|--------------|----|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Edna Rose Martin | | | | 2. Date of Death Month Day Year Dec 22, 1997 | | 3. Time of Death 6:40 AM | | | | | | | | | | | | | |
| | 4e. Facility Name (If not institution, give street and number) Augsburg Lutheran Home | | | | 4b. City, Town, or Location of Death Lochearn | | 4c. County of Death Baltimore | | | | | | | | | | | | | |
| Funeral Director | 5. Social Security Number 220-20-0192 | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 92 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) Oct 30, 1905 | 9. Birthplace (State or Foreign Country) Maryland | | | | | | | | | | | | | |
| | Usual Residence of Decedent | | | | | | | | | | | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State Maryland | 10b. County Howard | 10c. City, Town or Location Sykesville | | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | |
| | 10a. Street and Number 12340 Howard Lodge Drive | | | 10f. Zip Code 21784 | | 10g. Citizen of What Country? U.S.A. | | | | | | | | | | | | | | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | | | | | | | | | | | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 5th College (1-4 or 5+) College | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker | | 16b. Kind of Business/Industry Own Home | | | | | | | | | | | | | | | |
| | 17. Father's Name (First, Middle, Last) Walter E. Lanehart | | | 18. Mother's Name (First, Middle, Maiden Surname) Gertrude Clauss | | | | | | | | | | | | | | | | |
| | 19e. Informant's Name/Relationship (Type, Print) Mrs. Edna M. Martin | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12340 Howard Lodge Drive Sykesville, MD 21784 | | | | | | | | | | | | | | | | |
| | 20e. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Loudon Park Cemetery | | Date 12/26 | | 20c. Location - City or Town, State Baltimore City, MD | | | | | | | | | | | | | |
| | 21. Signature of Funeral Service Licensee Stephen M. Jenkins | | | 22. Name and Address of Facility Hubbard Funeral Home 4107 Wilkens Avenue Baltimore, MD 21229 | | | | | | | | | | | | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | | | | | | | | |
| | <table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a.</td> <td>Cardiomyopathy</td> <td>Approximate Interval Between Onset and Death</td> </tr> <tr> <td>b.</td> <td>valvular heart disease</td> <td>years</td> </tr> <tr> <td>c.</td> <td>aortic stenosis</td> <td>years</td> </tr> <tr> <td>d.</td> <td></td> <td></td> </tr> </table> | | | | | | | | Immediate Cause (Final disease or condition resulting in death) | a. | Cardiomyopathy | Approximate Interval Between Onset and Death | b. | valvular heart disease | years | c. | aortic stenosis | years | d. | |
| Immediate Cause (Final disease or condition resulting in death) | a. | Cardiomyopathy | Approximate Interval Between Onset and Death | | | | | | | | | | | | | | | | | |
| | b. | valvular heart disease | years | | | | | | | | | | | | | | | | | |
| | c. | aortic stenosis | years | | | | | | | | | | | | | | | | | |
| | d. | | | | | | | | | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | | | | | | | | | | | | |
| | | | | | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | | | | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 28. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | | | | | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury M | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | 28d. Describe how Injury occurred | | | | | | | | | | | | | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | | | | | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | | | | | | | | | | |
| 29b. Signature and title of certifier [Signature] | | | | 29c. License number D37573 | | 29d. Date signed (Month, Day, Year) Dec. 22, 1997 | | | | | | | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Sgt. Zibell MD 7220 Park Heights Ave Baltimore MD 21208 | | | | | | | | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 23 1997 | | 32. Registrar's Signature [Signature] | | | | | | | | | | | | | | | | | | |

SECRET

SECRET

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38737

Physician
/Medical
Examiner

Funeral
Director

| | | | | | | | |
|--|--|---|--|--|--------------------------------|--|--|
| 1. Decedent's Name (First, Middle, Last) Martha Jane McMillan | | | | 2. Date of Death Month December Day 20 Year 1997 | | 3. Time of Death 6:45pm | |
| 4a. Facility Name (If not institution, give street and number) Stella Maris Hospice at Mercy | | | | 4b. City, Town, or Location of Death Baltimore | | 4c. County of Death n/a | |
| 5. Social Security Number 245-20-9944 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 71 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) Aug. 18, 1926 | |
| 9. Birthplace (State or Foreign Country) North Carolina | | | | | | | |
| Usual Residence of Decedent | | | | | | | |
| 10a. State Maryland | | 10b. County Baltimore | | 10c. City, Town or Location Baltimore | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10e. Street and Number 9 Debonaire Ct. B-3 | | | | 10f. Zip Code 21234 | | 10g. Citizen of What Country? United States | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Black | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (14 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Domestic Engineer | | 16b. Kind of Business/Industry Homes | | | |
| 17. Father's Name (First, Middle, Last) Roger McMillan | | | | 18. Mother's Name (First, Middle, Maiden Surname) Jannie Finley | | | |
| 19e. Informant's Name/Relationship (Type, Print) Jeanette McMillan/Daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 Debonaire Ct., B-3, Baltimore, MD 21234 | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Vochelle Memorial Gardens 12-23-97 Baltimore, MD | | 20c. Location - City or Town, State | | | |
| 21. Signature of Funeral Service Licensee  | | | | 22. Name and Address of Facility CAFA - Stephen D. Lohrmann, P.A. 8717 Green Pastures Drive, Baltimore, MD 21286 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. metastatic Breast cancer Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) Stella Maris at Mercy Hospice | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. Describe how injury occurred | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| 29b. Signature and title of certifier  | | | | 29c. License number 040480 | | 29d. Date signed (Month, Day, Year) December 20, 1997 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Fernando J. Ferrer, MD 7672 Belair Rd Baltimore, MD 21236 | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 23 1997 | | | | Registrar's Signature  | | | |

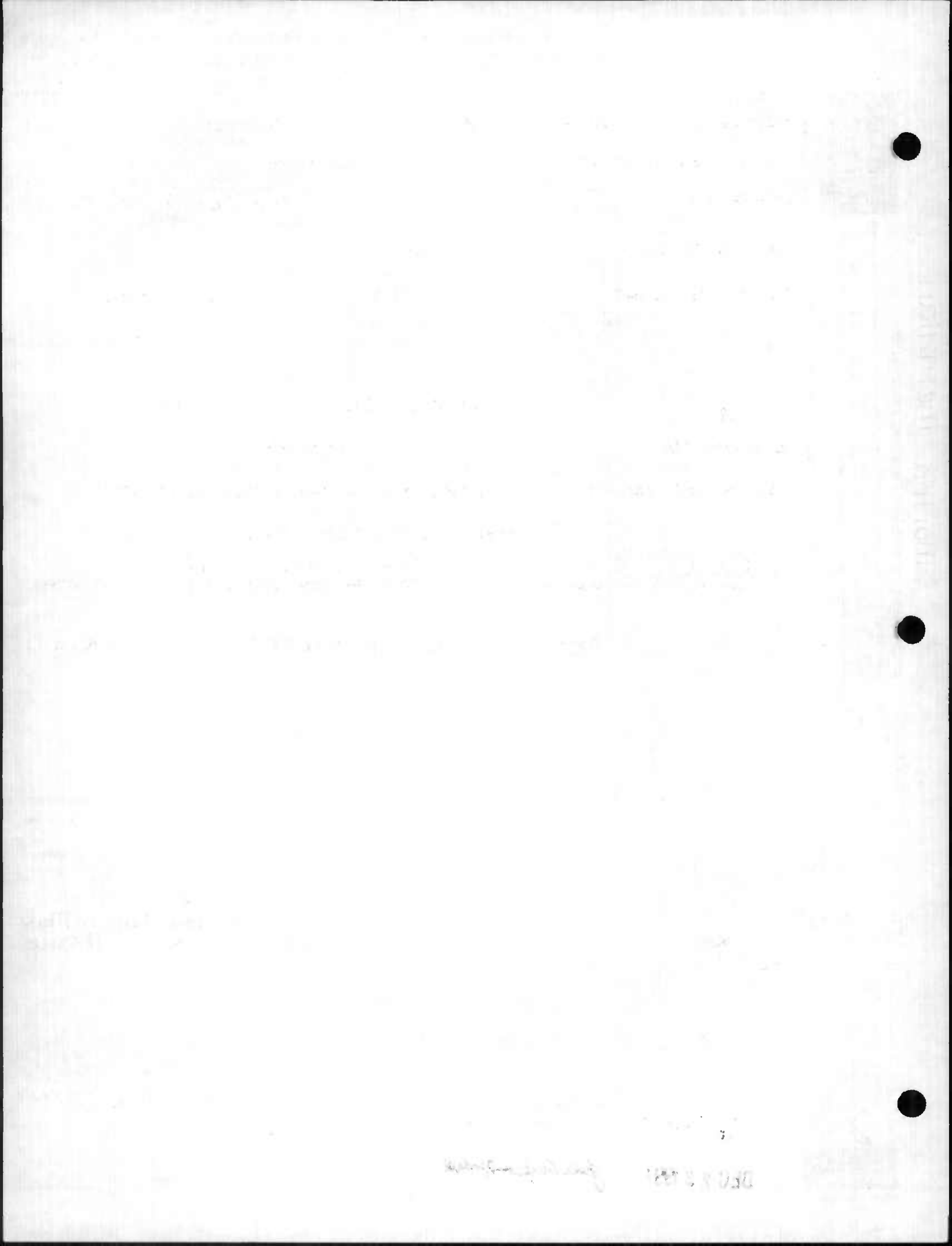
To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38738

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

KATHRYN MOSER

2. Date of Death

Month Day Year
DECEMBER 18th 1997

3. Time of Death

03.15 AM

4a. Facility Name (If not institution, give street and number)

Northwest Medical Center

4b. City, Town, or Location of Death

Randallstown

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

212-01-2414

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

87 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
July 16, 1910

9. Birthplace (State or Foreign Country)

Baltimore MD

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Owings Mills

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

4 Gwynnbrook Ave

10f. Zip Code

21117

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

housewife

16b. Kind of Business/Industry

own home

17. Father's Name (First, Middle, Last)

Howard Warneke

18. Mother's Name (First, Middle, Maiden Surname)

Elizabeth Dykleman

19a. Informant's Name/Relationship (Type, Print)

Frank D. Moser - Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4 Gwynnbrook Ave, Owings mills, MD 21117

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Carroll Cremation Service 12/19/97 Hampstead, MD

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

11824 Reisterstown Rd
Eline Funeral Home Reisterstown, MD 21136

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. PNEUMONIA
Due to (or as a consequence of):

2 WEEKS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. SEPSIS
Due to (or as a consequence of):

2 WEEKS

c. RECTAL BLEEDING
Due to (or as a consequence of):

2 WEEKS

d.

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature] P Mehta M.D.

29c. License number

041410

29d. Date signed (Month, Day, Year)

December 18th, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JOGINDER P MEHTA NORTHWEST HOSPITAL CENTER RANDALLSTOWN 21133 M.D.

31. Date filed (Month, Day, Year)

DEC 23 1997

32. Registrar's Signature

[Signature]

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permitted. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the final-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38739

| | | | | | | | | |
|--|---|--|--|---|--|--|--|---|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) WILLIAM MACKESSY | | | | 2. Date of Death Month December Day 18 Year 1997 | | 3. Time of Death 2:40pm | |
| | 4a. Facility Name (If not institution, give street and number) FRANKLIN SQUARE HOSPITAL | | | | 4b. City, Town, or Location of Death ROSEDALE | | 4c. County of Death BALTIMORE | |
| Funeral Director | 5. Social Security Number 217-14-2182 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 78 Yrs. | | 8. Date of Birth (Month, Day, Year) Nov. 29 1919 | |
| | 9. Birthplace (State or Foreign Country) Maryland | | 10a. State Md. | | 10b. County Baltimore | | 10c. City, Town or Location Essex | |
| 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 10e. Street and Number 24 Glenwood Road | | | | 10f. Zip Code 21221 |
| 10g. Citizen of What Country? USA | | | | 11. Marital Status <input type="checkbox"/> Navar Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: |
| 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: White | | | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4or 5+) |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Chemist | | | | 16b. Kind of Business/Industry Oil Company | | | | 17. Father's Name (First, Middle, Last) John Mackessy |
| 18. Mother's Name (First, Middle, Maiden Surname) Mary Schmidt | | | | 19a. Informant's Name/Relationship (Type, Print) Mary Hock /sister | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1311 Old Eastern Ave. Baltimore Md. 21221 |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory Inc. 12/19/97 | | | | 20c. Location - City or Town, State Baltimore Md. |
| 21. Signature of Funeral Service Licensee R. Terry Connelly | | | | 22. Name and Address of Facility Connelly Funeral Home of Essex 300 Mage Ave. Baltimore Md. 21221 | | | | Approximate Interval Between Onset and Death 10 days |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line. Cerebrovascular Accident Due to (or as a consequence of): Coronary Artery Disease Due to (or as a consequence of): Atrial Fibrillation Due to (or as a consequence of): | | | | | | | | 10 days |
| 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Colon Cancer | | | | 23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day, Year) | | | | 28b. Time of Injury M |
| 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 28d. Describe how injury occurred | | | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. Signature and title of certifier Michael F Piccu MD | | | | 29c. License number D0051356 |
| 29d. Date signed (Month, Day, Year) 12/18/97 | | | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9000 Franklin Square Drive, Rosedale MD, Michael F Piccu MD | | | | |
| 31. Date filed (Month, Day, Year) DEC 23 1997 | | | | 32. Registrar's Signature Julia Davidson-Randall | | | | |

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

1890-1891

0325-2345

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 38740

Certificate of Death

Reg. No.

| | | | | | | | | | |
|--|---|--|---|---|--|---|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) <i>Willie Newsome</i> | | | | 2. Date of Death Month <i>December</i> Day <i>20</i> Year <i>1997</i> | | 3. Time of Death <i>9:50 AM</i> | | |
| | 4e. Facility Name (If not institution, give street and number) <i>Northwest Hospital</i> | | | | 4b. City, Town, or Location of Death <i>Randallstown</i> | | 4c. County of Death <i>Harford</i> | | |
| Funeral Director | 5. Social Security Number <i>241-32-6855</i> | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (in yrs. last birthday) <i>74</i> Yrs. | | 8. Date of Birth (Month, Day, Year) <i>Sept. 13, 1923</i> | | |
| | 10a. State <i>MD</i> | | 10b. County <i>Baltimore</i> | | 10c. City, Town or Location <i>Randallstown</i> | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 10e. Street and Number <i>4103 Century Towne Road</i> | | | | 10f. Zip Code <i>21133</i> | | 10g. Citizen of What Country? <i>U.S.A.</i> | | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: <i>Black</i> | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>10th grade</i> College (1-4 or 5+) <i>N/A</i> | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>cab driver</i> | | | 16b. Kind of Business/Industry <i>Cab Company</i> | | | |
| 17. Father's Name (First, Middle, Last) <i>Hezekiah Newsome</i> | | | | 18. Mother's Name (First, Middle, Maiden Surname) <i>Kalicia Jones</i> | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) <i>Betty Newsome/wife</i> | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>4103 Century Towne Rd, Randallstown, Md 21133</i> | | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Woodlawn Cemetery</i> | | 20c. Location - City or Town, State <i>Baltimore, Md.</i> | | 20d. Date <i>12-26-97</i> | | |
| 21. Signature of Funeral Service Licensee <i>Gabriele Cook</i> | | | | 22. Name and Address of Facility <i>William C. March F/H - West 4300 Webster Ave Baltimore, Md 21215</i> | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <i>a. Renal cell cancer with metastasis</i> Due to (or as a consequence of): Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <i>b. Due to (or as a consequence of):</i> <i>c. Due to (or as a consequence of):</i> <i>d. Due to (or as a consequence of):</i> | | | | | | | | Approximate Interval Between Onset and Death | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | |
| | | | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how Injury occurred | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Certifying Physician: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. Signature and title of certifier <i>Alice Hiv</i> | | 29c. License number <i>H43974</i> | | 29d. Date signed (Month, Day, Year) <i>December 20, 1997</i> | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <i>Northwest Hospital, Randallstown, Md Alice Hiv</i> | | | | | | | | | |
| 31. Date filed (Month, Day, Year) <i>DEC 23 1997</i> | | | | 32. Registrar's Signature <i>John Davidson-Randall</i> | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permt. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

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Physician
/Medical
Examiner

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To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Item#31 perVR G754 12/23/97 EW

97 38741

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

DORIS NEUMANN

2. Date of Death

Month Day Year
DECEMBER 19 1997

3. Time of Death

4:40pm

4a. Facility Name (If not institution, give street and number)

Good Samaritan Hospital

4b. City, Town, or Location of Death

Baltimore City

4c. County of Death

5. Social Security Number

215 28 8067

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

66 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

July 17 1931

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland Baltimore

10b. County

Parkville

10c. City, Town or Location

Parkville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8626 Willow Oak Rd.

10f. Zip Code

21234

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

Covers

College (1-4 or 5+)

—

18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

homemaker

16b. Kind of Business/Industry

home

17. Father's Name (First, Middle, Last)

Earle A. Nodine Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Levisa H. Sellers

19a. Informant's Name/Relationship (Type, Print)

Richard H. Neumann Sr.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8626 Willow Oak Rd. Parkville Md. 21234

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Dulakey Valley Mem. Garden

Date

Dec. 23 1997

20c. Location - City or Town, State

Timonium, Maryland

21. Signature of Funeral Service Licensee

Krisa S. Wells

22. Name and Address of Facility

Evans Funeral Chapel
8800 Harford Rd. Baltimore, Md 21234

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Metastatic Breast carcinoma

Approximate Interval Between Onset and Death

6 months

Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Upper Gastrointestinal bleeding

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Jihad Alhariri MD

29c. License number

P 11389

29d. Date signed (Month, Day, Year)

Dec 19 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JIHAD ALHARIRI MD.

GOOD SAMARITAN HOSPITAL

31. Date filed (Month, Day, Year)

December 19 1997

32. Registrar's Signature

DEC 23 1997

Julia Davidson-Rodriguez

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

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Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38742

| | | | | | | | | |
|--|--|---|--|--|--|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) EMMA ELIZABETH NEUMYER | | | | 2. Date of Death Month Day Year December 20, 1997 | | 3. Time of Death 8:52 AM | |
| | 4a. Facility Name (If not institution, give street and number) St. Agnes Nursing & Rehabilitation Center | | | | 4b. City, Town, or Location of Death Ellicott City | | 4c. County of Death Howard | |
| Funeral Director | 5. Social Security Number 217-26-1425A | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 93 Yrs. | | 8. Date of Birth (Month, Day, Year) Oct 22, 1904 | |
| | 9. Birthplace (State or Foreign Country) Pennsylvania | | 10a. State Maryland | | 10b. County Howard | | 10c. City, Town or Location Ellicott City | |
| 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 10e. Street and Number 3000 N. Ridge Rd. | | 10f. Zip Code 21043 | | 10g. Citizen of What Country? USA | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 years College (1-4or 5+) 4 years | | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker | | 16b. Kind of Business/Industry Own Home | | 17. Father's Name (First, Middle, Last) John Jacob Wurst | | |
| 18. Mother's Name (First, Middle, Maiden Surname) Josephine Unknown | | 19a. Informant's Name/Relationship (Type, Print) Dorothea Wehland (Daughter) | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5208 Font Ave. Ellicott City, MD 21043 | | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | |
| 20b. Place of Disposition (Name of cemetery, crematory or other place) Lake View Memorial Park | | 20c. Date 12-23 | | 20d. Location - City or Town, State Sykesville, Maryland | | 21. Signature of Funeral Service Licensee John K. Anderson | | |
| 22. Name and Address of Facility Loring Byers Funeral Directors, Inc. 8728 Liberty Rd. Randallstown, MD 21133 | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. a. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE Due to (or as a consequence of): | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | 23c. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| 23d. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | |
| 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier Farusheen Saleem | | 29c. License number D 28595 | | 29d. Date signed (Month, Day, Year) 12/22/97 | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) TASNEEM LAKHANI, 7222 PARK HEIGHTS AVE BALTO MD 21208 | | 31. Date filed (Month, Day, Year) DEC 23 1997 | | 32. Registrar's Signature John A. Anderson | | 33. Registrar's Title Registrar | | |

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38743

| | | | | | | | | |
|---|---|---|--|--|--|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) KEITH JOSEPH NELSON | | | | 2. Date of Death Month December Day 20 Year 1997 | | 3. Time of Death 10:00 p.m. | |
| | 4a. Facility Name (If not Institution, give street and number) Maryland General Hospital Baltimore City | | | | 4b. City, Town, or Location of Death Baltimore City | | 4c. County of Death N/A | |
| Funeral Director | 5. Social Security Number 219-11-2806 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 29 Yrs. | | 8. Date of Birth (Month, Day, Year) SEPT. 28, 1968 | |
| | 9. Birthplace (State or Foreign Country) MARYLAND | | 10a. State MARYLAND | | 10b. County N/A | | 10c. City, Town or Location Baltimore City | |
| 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number 3815 BEEHLER AVENUE | | 10f. Zip Code 21215 | | 10g. Citizen of What Country? USA | | |
| 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: BLACK | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10+H GRADE College (1-4 or 5+) UNKNOWN | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) UNKNOWN | | 16b. Kind of Business/Industry UNKNOWN | | 17. Father's Name (First, Middle, Last) MILTON NELSON | | |
| 18. Mother's Name (First, Middle, Maiden Surname) LUCILLE ROGERS | | 19a. Informant's Name/Relationship (Type, Print) PRISCILLA BROOKS (SISTER) | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6 APPLEGATE COURT, BALTIMORE, MD. 21208 | | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | |
| 20b. Place of Disposition (Name of cemetery, crematory or other place) KING MEMORIAL PARK | | 20c. Location - City or Town, State 12-26-97 WOODLAWN, MARYLAND | | 21. Signature of Funeral Service Licensee D. Brown | | 22. Name and Address of Facility JOSEPH H. BROWN JR. FUNERAL HOME, PA 2140 N. FULTON AVE., BALTIMORE, MD. 21217 | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <div style="display: flex; justify-content: space-between;"> <div style="width: 30%;"> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</p> </div> <div style="width: 60%;"> <p>a. End Stage Acquired Immune Deficiency Syndrome Due to (or as a consequence of):</p> <p>b. Anemia Due to (or as a consequence of):</p> <p>c. MALNUTRITION Due to (or as a consequence of):</p> <p>d.</p> </div> </div> | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | |
| 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 28g. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| 29b. Signature and title of certifier Maleeha Chaudary, MD | | 29c. License number 89287 | | 29d. Date signed (Month, Day, Year) December 21, 1997 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. Maleeha Chaudary 40 Maryland General Hospital | | |
| 31. Date filed (Month, Day, Year) DEC 23 1997 | | 32. Registrar's Signature Julia Davidson-Randall | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Handwritten signature

1931.1.23

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Item: 18 Per Informat Film G-755 1-22-98RC

Certificate of Death

Reg. No.

97 38744

| | | | | | | | | |
|--|---|---|---|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Helen Marie Nelson | | | | 2. Date of Death Month Day Year December 5, 1997 | | 3. Time of Death 3:30 PM | |
| | 4a. Facility Name (If not institution, give street and number) Gensis Spa Creek Nursing Home | | | | 4b. City, Town, or Location of Death Annapolis | | 4c. County of Death Anne Arundel | |
| Funeral Director | 5. Social Security Number 217-40-1863 | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 54 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) Sept. 6, 1943 | | 9. Birthplace (State or Foreign Country) D.C. |
| | Usual Residence of Decedent | | | | | | | |
| To Be Completed by Funeral Director | 10a. State Maryland | 10b. County Anne Arundel | 10c. City, Town or Location Annapolis | | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| | 10e. Street and Number 3500 Milkshake Lane | | | 10f. Zip Code 21403 | | 10g. Citizen of What Country? U.S.A. | | |
| | 11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever In U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: white | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 Collage (1-4 or 5+) 0 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Auditor | | 16b. Kind of Business/Industry Financial industry | | | |
| | 17. Father's Name (First, Middle, Last) Ralph P. Nelson | | | | 18. Mother's Name (First, Middle, Maiden Surname) HARRIETT CATHERINE LYLES H. Catherine unknown | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Angel Foster/daughter | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1221 Springwood Ct., Arnold, MD 21012 | | | | |
| | 20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) | | 20c. Location - City or Town, State | | |
| | 21. Signature of Funeral Service Licensee Ronald S. Wade, Director | | | 22. Name and Address of Facility State Anatomy Board, 655 W. Baltimore Street Baltimore, MD 21201 | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. a. GLIOBLASTOMA Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | | | | | | Approximate Interval Between Onset and Death 1 1/2 - 2 years |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |
| | | | | | | | 24e. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred |
| | | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| 29b. Signature and title of certifier Robert F. Verkoren, MD | | 29c. License number D11653 | | 29d. Date signed (Month, Day, Year) Dec. 16, 1997 | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robert F. Verkoren, MD 2003 MED Parkway Annapolis, MD, 21401 | | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 23 1997 | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 38745

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Wardell E. Owens Sr.

2. Date of Death

December 19 1997

3. Time of Death

11:30 AM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Union Memorial Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

5. Social Security Number

220-24-0468

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

66 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

6 15 31

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD.

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

4210 Flowerton Rd.

10f. Zip Code

21229

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.Specify:
Afro-American15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Mechanic

16b. Kind of Business/Industry

Baltimore City Transportation

17. Father's Name (First, Middle, Last)

Leonard Owens

18. Mother's Name (First, Middle, Maiden Surname)

Viola Johnson

19a. Informant's Name/Relationship (Type, Print) (wife)

Mrs. Irene Owens

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4210 Flowerton Rd. Balto, Md. 21229

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Garrison Forest Cem.

Date

12/24/97

20c. Location - City or Town, State

Owings Mill Md.

21. Signature of Funeral Service Licensee

Joseph L. Russ

22. Name and Address of Facility

Joseph L. Russ 2222 W. North Ave
Balto, MD. 2121623a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)a. Malignant brain tumor
Due to (or as a consequence of):Approximate
Interval Between
Onset and Death

3 months

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

high blood sugar
g.i. hemorrhage

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

J. Russ

29c. License number

AT 2438946

29d. Date signed (Month, Day, Year)

December 19, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1910 Sulgrave Ave Baltimore MD 21209

31. Date filed (Month, Day, Year)

DEC 22 1997

32. Registrar's Signature

J. Russ

State
Registrar

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38746

| | | | | | |
|---|---|---|---|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) EDWARD OFFER | | 2. Date of Death Month DECEMBER Day 21 Year 1997 | | 3. Time of Death 4:50 P |
| | 4a. Facility Name (If not institution, give street and number) Liberty Medical Center | | 4b. City, Town, or Location of Death Baltimore | | 4c. County of Death n/a |
| Funeral Director | 5. Social Security Number 220-20-2291 | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 69 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. |
| | 8. Date of Birth (Month, Day, Year) May 13, 1928 | | 9. Birthplace (State or Foreign Country) Md. | | |
| To Be Completed by Funeral Director | Usual Residence of Decedent | | 10a. State Md. | | 10b. County n/a |
| | 10c. City, Town or Location Baltimore | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | 10e. Street and Number 2208 Clifton Avenue | | 10f. Zip Code 21216 | | 10g. Citizen of What Country? USA |
| | 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
| | 14. Race - American Indian, Black, White, etc. Specify: Black | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th Grade College (1-4or 5+) | | |
| To Be Completed by Physician/Medical Examiner | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Insurance Salesman | | 16b. Kind of Business/Industry North Carolina Mutual Insurance Company | | |
| | 17. Father's Name (First, Middle, Last) Lawrence Offer | | 18. Mother's Name (First, Middle, Maiden Surname) Catherine Wilson | | |
| | 19a. Informant's Name/Relationship (Type, Print) son Tyrone E. Offer | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2208 Clifton Avenue Baltimore, Md. 21216 | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Md. National Memorial Park Dec. 26 Laurel, Md. | | Date |
| | 21. Signature of Funeral Service Licensee  | | 22. Name and Address of Facility Nutter Funeral Homes, Inc. 2501 Gwynns Falls PKWY Baltimore, Md. 21216 | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | Approximate Interval Between Onset and Death |
| Immediate Cause (Final disease or condition resulting in death) | | | | | |
| a. VENTRICULAR FIBRILLATION Due to (or as a consequence of): | | | | | 30 Mins |
| b. CARDIOMYOPATHY Due to (or as a consequence of): | | | | | unknown |
| c. WITH CONGESTIVE HEART FAILURE Due to (or as a consequence of): | | | | | " |
| d. | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. HYPERTENSION | | | | | |
| 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | 28b. Time of injury M | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | 28d. Describe how Injury occurred |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier  MD. | | | |
| 29c. License number D 23300 | | 29d. Date signed (Month, Day, Year) DECEMBER 21 1997 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SUDHIR D. PATEL 2600 Liberty RD. BALTO. MD. 21215 | | | | | |
| 31. Date filed (Month, Day, Year) DEC 23 1997 | | 32. Registrar's Signature  | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38747

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

AILEAN J. POPE

2. Date of Death

Month

Day

Year

Dec 18, 1997

3. Time of Death

7:25 AM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Bon Secours Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

NA

5. Social Security Number

240-44-2716

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

66 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
2-12-1931

9. Birthplace (State or Foreign Country)

N.C.

Usual Residence of Decedent

10a. State
Md

10b. County

NA

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

139 N. Calver Street

10f. Zip Code

21229

10g. Citizen of What Country?

U.S.A

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th grade

College (14 or 5+)

2 yrs

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

House wife

16b. Kind of Business/Industry

Home

17. Father's Name (First, Middle, Last)

Maryon Hall

18. Mother's Name (First, Middle, Maiden Surname)

Sevene Manning

19a. Informant's Name/Relationship (Type, Print)

Shadrick Pope - Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

139 N. Calver Street Baltimore, Md 21229

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Garden of Eternal Hope

Date

12-23-97

20c. Location - City or Town, State

Westminster, Md

21. Signature of Funeral Service Licensee

▶ Gladys Wane

22. Name and Address of Facility

Manly F.H. West 21215
4300 Wabash Avenue Baltimore

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Congestive Heart FAILURE

Due to (or as a consequence of):

Cardiomyopathy

Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Chronic Obstructive Lung Diseases

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

▶ R. M. Shah

29c. License number

D19668

29d. Date signed (Month, Day, Year)

Dec 18, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

R. M. SHAH, MD, Bon Secours Hospital, Baltimore, MD

31. Date filed (Month, Day, Year)

DEC 23 1997

Registrar's Signature

John Davidson-Rodriguez

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

BETTY PERKINS

ASP

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38748

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician / Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | | |
|---|--|--|---|--|--|
| 1. Decedent's Name (First, Middle, Last) BETTY JEAN PERKINS | | 2. Date of Death Month Day Year DECEMBER 21 1997 | | 3. Time of Death 2:35 A | |
| 4a. Facility Name (If not institution, give street and number) 1300 BLK N. WOLFE ST. | | | 4b. City, Town, or Location of Death BALTIMORE | | 4c. County of Death N/A |
| 5. Social Security Number 214-68-4819 | 8. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 36 Yrs. | If Under 1 Year Month Days | If Under 24 Hrs. Hour Min. | 8. Date of Birth (Month, Day, Year) September 13, 1961 MD |
| Usual Residence of Decedent | | | | | |
| 10a. State Maryland | 10b. County N/A | 10c. City, Town or Location Baltimore City | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10e. Street and Number 92 Twin Circle | | 10f. Zip Code 21227 | | 10g. Citizen of What Country? U.S.A. | |
| 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Sanitation Engineer | | 16b. Kind of Business/Industry Maintenance | |
| 17. Father's Name (First, Middle, Last) Lessiel Perkins | | | 18. Mother's Name (First, Middle, Maiden Surname) Helen Palmer | | |
| 19a. Informant's Name/Relationship (Type, Print) Linda Marie Perkins/Sister | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3921 1/2 Norfolk Avenue Baltimore, Md 21216 | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) King Memorial Park 27, 1997 | | 20c. Location - City or Town, State Baltimore, Maryland | |
| 21. Signature of Funeral Service Licensee <i>Margaleen Gilmore Henson</i> | | | 22. Name and Address of Facility Margaleen Gilmore Henson, Mortician Doing Business from Chatman-Road Baltimore, Maryland 21215 | | |
| 23a. Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. Head Injuries Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | | | | Approximate Interval Between Onset and Death |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| | | | | | 24a. Was an autopsy performed? partial <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) SCENE | | | |
| 27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) 12-21-97 | 28b. Time of Injury 0720 M | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | 28d. Describe how injury occurred passenger auto - auto collision |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Roadway | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1300 blk N. Wolfe St | |
| 29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier <i>[Signature]</i> | | 29c. License number O.C.M.E | |
| | | 29d. Date signed (Month, Day, Year) DECEMBER 21, 1997 | | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) David R Fowler 111 Penn Street, Baltimore, Maryland 21201 | | | | | |
| 31. Date filed (Month, Day, Year) DEC 23 1997 | | 32. Registrar's Signature <i>[Signature]</i> | | | |

Handwritten signature or mark

100-100

97-6842-510

jhm

DENNIS

PAZDZCORA Items: 23 part I, 27 per ME0 G-754 12/23/97 ^{dh} **Certificate of Death**

Reg. No.

97 38749

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

DENNIS PAZDZIORKO

2. Date of Death

Month Day Year
NOVEMBER 26, 1997

3. Time of Death

07:15 AM

4a. Facility Name (If not institution, give street and number)

2436 FLEET STREET

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

UNKNOWN

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

43 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
7-2-54

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2436 FLEET STREET

10f. Zip Code

21224

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: WHITE

To Be Completed by Funeral Director

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

10 YEARS

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

STOCK ROOM CLERK

16b. Kind of Business/Industry

ST. OF MARYLAND

17. Father's Name (First, Middle, Last)

ALOYSIUS PAZDZIORKO

18. Mother's Name (First, Middle, Maiden Surname)

JOSEPHINE KULESZA

19a. Informant's Name/Relationship (Type, Print)

MR. ALOYSIUS PAZDZIORKO

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2436 FLEET ST. BALTO. MD. 21224

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

GREEN MOUNT CEM.

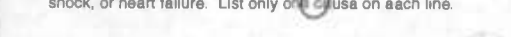
Date

12-1

20c. Location - City or Town, State

BALTO. MD.

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

KACZOROWSKI FUNERAL HOME
2525 FLEET ST. BALTO. MD. 2122423a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.

SEIZURE DISORDER

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Approximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☒ Yes 2 ☐ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☒ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☒ Pending investigation
6 ☐ Could not be determined28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

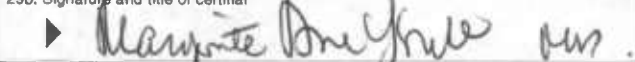
M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier



29c. License number

OCME

29d. Date signed (Month, Day, Year)

NOVEMBER 26, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MAYOR PAUL D. KOSOW 111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

DEC 23 1997

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be completed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38750

| | | | | | | | | |
|--|---|---------------------------------|---|--|---|--------------------------------|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) MARY PENNINGTON | | | | 2. Date of Death Month NOV Day 29 Year 1997 | | 3. Time of Death 1618 | |
| | 4a. Facility Name (If not institution, give street and number) U. MARYLAND - SHOCK TRAUMA CENTER | | | | 4b. City, Town, or Location of Death BALTIMORE, MD | | 4c. County of Death BALTIMORE | |
| Funeral Director | 5. Social Security Number 213-36-1223 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 57 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) JAN 26 1940 | 9. Birthplace (State or Foreign Country) |
| | Usual Residence of Decedent | | | | | | | |
| To Be Completed by Funeral Director | 10a. State MD | 10b. County BALTIMORE | 10c. City, Town or Location 403 SOUTH PARRISH, BALTIMORE MD | | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| | 10e. Street and Number 403 SOUTH PARRISH | | | | 10f. Zip Code 21223 | | 10g. Citizen of What Country? USA | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: CAUCASIAN | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8TH GRADE College (1-4 or 5+) N/A | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) SEAMSTRESS | | 16b. Kind of Business/Industry CLEANING | | | |
| Physician /Medical Examiner | 17. Father's Name (First, Middle, Last) JAME H. THOMPSON | | | | 18. Mother's Name (First, Middle, Maiden Surname) MARY C. DRAGER | | | |
| | 19a. Informant's Name/Relationship (Type, Print) THEODORE THOMPSON / BROTHER | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 403 S. PARRISH ST., BALTO. MD 21223 | | | |
| | 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) METRO CREMATORY | | 20c. Location - City or Town, State BALTO. MD | | 20d. Date | |
| | 21. Signature of Funeral Service Licensee Vaughn C. Greene | | 22. Name and Address of Facility VAUGHN C. GREENE FUNERAL SERVICE 5151 BALTO. NATL PIKE, BALTO. MD. 21229 | | | | | |
| Physician /Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. CARDIOPULMONARY ARREST Due to (or as a consequence of): b. CARDIAC FAILURE Due to (or as a consequence of): c. PULMONARY FAILURE Due to (or as a consequence of): d. RENAL FAILURE | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | |
| | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | |
| | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. MULTISYSTEM ORGAN FAILURE NECROTIZING SOFT TISSUE INFECTION | | | | | | | |
| | 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) - NA - | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) - NA - | | 28d. Describe how injury occurred - NA - | | | | | |
| State Registrar | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| | 29b. Signature and title of certifier Imhotep Donahue MD | | | | 29c. License number D0052135 | | 29d. Date signed (Month, Day, Year) Nov 29, 1997 | |
| | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) SHOCK TRAUMA CENTER - UNIV. MD - 22 SOUTH GREENE ST, BALTIMORE MD | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 23 1997 | | | | 32. Registrar's Signature Johanna Davidson-Randall | | | | |

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38751

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Harry Parker

2. Date of Death

December 17, 1997

Day

Year

3. Time of Death
0635AM

4a. Facility Name (If not institution, give street and number)

Sinai Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

212-18-4866

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

84

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

6-26-13

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State
MD

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

141 N. CULVER ROAD

10f. Zip Code

21229

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

5TH GRADE

College (1-4 or 5+)

N/A

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

FOREMAN / PUBC WORKS

16b. Kind of Business/Industry

BALTO. CITY

17. Father's Name (First, Middle, Last)

WILLIAM F. PARKER

18. Mother's Name (First, Middle, Maiden Surname)

MARY GOFF

19a. Informant's Name/Relationship (Type, Print)

NETTIE BEASLEY / DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

141 N. CULVER RD., BALD. MD 21229

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

CROWNSVILLE CEMETERY

Date

12-22-97

20c. Location - City or Town, State

CROWNSVILLE, MD

21. Signature of Funeral Service Licensee

Vaughn C. Greene

22. Name and Address of Facility

VAUGHN C. GREENE FUNERAL SERVICE

5151 BALD. NATL PIKE, BALTO. MD 21229

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. gram negative sepsis

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home

5 ☐ Residence

8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Patrice Green MD

29c. License number

2402321PG 9024

29d. Date signed (Month, Day, Year)

December 17, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Patrice Green, MD Sinai Hospital, Baltimore, Maryland

31. Date filed (Month, Day, Year)

DEC 23 1997

32. Registrar's Signature

Jake Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

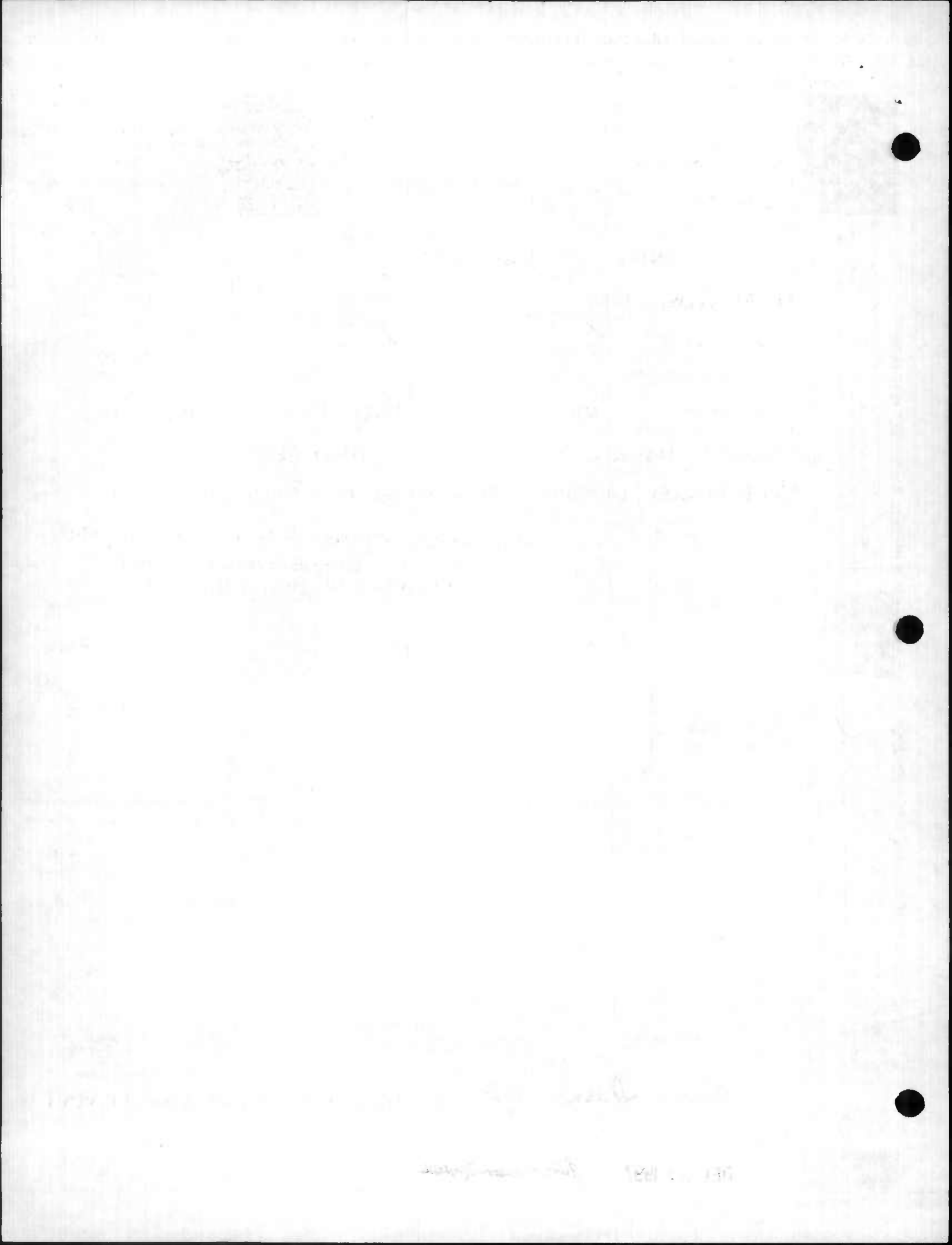
Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38752

| | | | | | | | | |
|---|--|--|--|--|--|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Jesse B. Pollard | | | | 2. Date of Death Month Day Year Dec. 16, 1997 | | 3. Time of Death 5.50 P.M. | |
| | 4a. Facility Name (If not institution, give street and number) Balto. Rehab Extended Care Center | | | | 4b. City, Town, or Location of Death BALTIMORE | | 4c. County of Death n/a | |
| Funeral Director | 5. Social Security Number 214-24-1097 | | 6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 70 Yrs. | | 8. Date of Birth (Month, Day, Year) Dec. 3, 1927 | |
| | 9. Birthplace (State or Foreign Country) Virginia | | 10a. State Md. | | 10b. County Baltimore | | 10c. City, Town or Location Essex | |
| To Be Completed by Funeral Director | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 10e. Street and Number 1907 Old Eastern Avenue | | 10f. Zip Code 21221 | |
| | 10g. Citizen of What Country? USA | | | | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: | |
| To Be Completed by Physician/Medical Examiner | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: White | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12th | |
| | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Machinist | | | | 16b. Kind of Business/Industry Bethlehem Steel | | | |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last) Jesse B. Pollard Sr. | | | | 18. Mother's Name (First, Middle, Maiden Surname) Blanche Pugh | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Robert Pollard/son | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6924 Myers View Drive Baltimore, Md. 21220 | | | |
| To Be Completed by Physician/Medical Examiner | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Holly Hill Cemetery | | 20c. Location - City or Town, State Baltimore, Md. | |
| | 21. Signature of Funeral Service Licensee R. Teroy Connelly | | | | 22. Name and Address of Facility Connelly Funeral Home of Essex 300 Mace Avenue Baltimore, Md. 21221 | | | |
| To Be Completed by Physician/Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Chronic Renal failure Due to (or as a consequence of): b. Peripheral vascular disease Due to (or as a consequence of): c. Arteriosclerosis Due to (or as a consequence of): d. Diabetes | | | | Approximate Interval Between Onset and Death 10 years | | | |
| | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| To Be Completed by Physician/Medical Examiner | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | | |
| To Be Completed by Physician/Medical Examiner | 28a. Date of Injury (Month, Day Year) | | | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | 28d. Describe how injury occurred | | | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. Signature and title of certifier Perry L. Colvin MD | | | |
| | 29c. License number D32548 | | | | 29d. Date signed (Month, Day, Year) December 17, 1997 | | | |
| To Be Completed by Physician/Medical Examiner | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Perry L. Colvin, MD | | | | 31. Date filed (Month, Day, Year) DEC 23 1997 | | | |
| | 32. Registrar's Signature John Davidson-Randall | | | | 33. Date of Death (Month, Day, Year) DEC 16, 1997 | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

38753

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

REBECCA BONNER QUILLE

2. Date of Death

Month
12Day
21Year
97

3. Time of Death

8:45AM

4a. Facility Name (If not institution, give street and number)

4124 RONIS ROAD

4b. City, Town, or Location of Death

PIKESVILLE

4c. County of Death

BALTIMORE

5. Social Security Number

172-22-2934

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

76

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

7

21

31

9. Birthplace (State or Foreign Country)

GEORGIA

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

BALTIMORE

10c. City, Town or Location

PIKESVILLE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

4124 RONIS ROAD

10f. Zip Code

21208

10g. Citizen of What Country?

US

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

6

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

COUNSELOR

16b. Kind of Business/Industry

EDUCATION

17. Father's Name (First, Middle, Last)

THOMAS E. BONNER

18. Mother's Name (First, Middle, Maiden Surname)

REBECCA JONES

19a. Informant's Name/Relationship (Type, Print)

ALLEN QUILLE JR. (SON)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9980 VILLAGE GREEN DR. WOODSTOCK, MD. 21163

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

DRUID RIDGE CEMETERY

Date

12/24

20c. Location - City or Town, State

BALTIMORE, MD.

21. Signature of Funeral Service Licensee

Donata E. CFSO

22. Name and Address of Facility

E.L. PHILLIPS FUNERAL HOME 1721-27 N. MONROE STREET BALTIMORE, MD. 21217

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. *acute myocardial infarction*
Due to (or as a consequence of)

Approximate Interval Between Onset and Death

1 hour

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. *aspiration pneumonia*
Due to (or as a consequence of):

5 days

c. *cerebrovascular accident*
Due to (or as a consequence of):

6 years

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

seizure disorder

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Timothy J. Kay M.D.

29c. License number

D37458

29d. Date signed (Month, Day, Year)

12/22/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Timothy J. Kay M.D. 22 S. Park St. Baltimore, MD 21201

31. Date filed (Month, Day, Year)

DEC 23 1997

32. Registrar's Signature

*John Anderson-Randall*State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permitted. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38754

| | | | | | | | | |
|--|--|--|---------------------------------|---|--|---|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Mattie G. Richardson | | | | 2. Date of Death Month 12 Day 18 Year 97 | | 3. Time of Death 1:15 PM | |
| | 4a. Facility Name (If not institution, give street and number) 5218 Ivanhoe Ave. | | | | 4b. City, Town, or Location of Death Balto. MD. | | 4c. County of Death N/A | |
| Funeral Director | 5. Social Security Number 352-30-8153 | | 6. Sex 1 M 2 F | 7. Age (In yrs. last birthday) 84 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) 9 5 13 | 9. Birthplace (State or Foreign Country) Georgia |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State MD. | | 10b. County N/A | | 10c. City, Town or Location Baltimore | | | 10d. Inside City Limits 1 Yes 2 No | |
| 10e. Street and Number 5218 Ivanhoe Ave | | | | 10f. Zip Code 21212 | | 10g. Citizen of What Country? USA | | |
| 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Black | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8th College (1-4 or 5+) 0 | | | | 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) DOMESTIC | | 16b. Kind of Business/Industry Private Home | | |
| 17. Father's Name (First, Middle, Last) John Ringer | | | | 18. Mother's Name (First, Middle, Maiden Surname) Ella Fields | | | | |
| 19e. Informant's Name/Relationship (Type, Print) Mrs. Lestine Hall (Daughter) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5218 Ivanhoe Ave Balto. MD 21212 | | | | |
| 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Vosshell Gardens | | Date 12/23/97 | | 20c. Location - City or Town, State Balto. Co. Md. | | |
| 21. Signature of Funeral Service Licensee Joseph L. Russ | | | | 22. Name and Address of Facility Joseph L. Russ Funeral Home 2002 W. North Ave. Baltimore Md 21216 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. congestive heart failure Due to (or as a consequence of): b. arteriosclerotic cardiovascular disease Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Approximate Interval Between Onset and Death 1 week more than 10 years | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CVA & dementia and dysphagia, pressure ulcer | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown | | |
| 24e. Was an autopsy performed? 1 Yes 2 No | | 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No | | | | | | |
| 25. Was case referred to medical examiner? 1 Yes 2 No | | 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) | | | | | | |
| 27. Manner of Death 1 Natural 5 Pending investigation 2 Accident 6 Could not be determined 3 Suicide 4 Homicide | | 28e. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 Yes 2 No | | 28d. Describe how injury occurred |
| 29e. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier Timothy J. Keay, MD | | 29c. License number D37458 | | 29d. Date signed (Month, Day, Year) 12/22/97 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Timothy J. Keay, MD Postmaster 29 S. Laca St Baltimore, MD 21201 | | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 23 1997 | | 32. Registrar's Signature John Davidson-Rodriguez | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

Reg. No.

87 38755

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last) Dazee E. Rawlings 2. Date of Death Month DEC Day 19 Year 1997 3. Time of Death 5:50 AM

Funeral
Director

4a. Facility Name (If not institution, give street and number) Villa St Michael Nursing + Rehab Center 4b. City, Town, or Location of Death Baltimore 4c. County of Death N/A
 5. Social Security Number 216-16-4567 8. Sex ☐ M ☒ F 7. Age (In yrs. last birthday) 74 Yrs. If Under 1 Year Months Days If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year) 9-19-1923 9. Birthplace (State or Foreign Country) BALTO. MD

To Be Completed by Funeral Director

Usual Residence of Decedent 10a. State Maryland 10b. County N/A. 10c. City, Town or Location BALTIMORE 10d. Inside City Limits ☒ Yes ☐ No
 10a. Street and Number 3307 Ferndale Ave. 10f. Zip Code 21207 10g. Citizen of What Country? U.S.A.
 11. Marital Status ☐ Never Married ☐ Married ☒ Widowed ☐ Divorced 12. Was Decedent Ever in U.S. Armed Forces? ☐ Yes ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ☐ Yes ☒ No Specify: 14. Race - American Indian, Black, White, etc. Specify: AMERICAN

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 3 18e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) School Teacher 16b. Kind of Business/Industry BALTO. Public School

17. Father's Name (First, Middle, Last) Oliver Creigler 18. Mother's Name (First, Middle, Maiden Surname) Anita Tankard

19a. Informant's Name/Relationship (Type, Print) Mr. Oliver Rawlings 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21 Remond Ct. Baltimore Md. 21234

20a. Method of Disposition ☐ Burial ☒ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Greenmount Cem Date 12/29/97 20c. Location - City or Town, State BALTO. MD

21. Signature of Funeral Service Licensee Joseph L. Russ 22. Name and Address of Facility Joseph L. Russ Funeral Home
2332 W. North Ave. Baltimore Md 21216

Physician
/Medical
Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
 Immediate Cause (Final disease or condition resulting in death) a. END STAGE RENAL DISEASE Approximate Interval Between Onset and Death 10 YEARS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. DIABETES MELLITUS and HYPERTENSION
 Due to (or as a consequence of):
 c. Due to (or as a consequence of):
 d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1st af stroke c weakness 23b. Did tobacco use contribute to the cause of death? ☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed? ☐ Yes ☒ No 24b. Were autopsy findings available prior to completion of cause of death? ☐ Yes ☒ No

25. Was case referred to medical examiner? ☐ Yes ☒ No 26. Place of Death (Check only one) Hospital: ☐ Inpatient ☐ ER/Outpatient ☐ DOA Other: ☒ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death ☒ Natural ☐ Pending Investigation ☐ Accident ☐ Suicide ☐ Homicide ☐ Could not be determined 28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? ☐ Yes ☒ No 28d. Describe how injury occurred 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier Deborah I. Pierce 29c. License number H45931 29d. Date signed (Month, Day, Year) December 17, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Deborah I. Pierce 52 MAIN ST. PLEISTOWTOWN. MD

State
Registrar

31. Date filed (Month, Day, Year) DEC 23 1997 32. Registrar's Signature John Davidson

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

DAZEE RAWLINGS

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 37 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38756

| | | | | | | | | | | | |
|---|---|--|--|--|---|--|--------------------------------|--|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Willie Rogers | | | | 2. Date of Death Month Day Year December 21, 1997 | | | | 3. Time of Death 6:15 AM | | |
| | 4a. Facility Name (If not Institution, give street and number) MARYLAND General Hospital | | | | 4b. City, Town, or Location of Death Baltimore City | | | | 4c. County of Death n/a | | |
| Funeral Director | 5. Social Security Number 245-18-3631 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 82 Yrs. | | If Under 1 Year Months Days | | If Under 24 Hrs. Hours Min. | | |
| | 8. Date of Birth (Month, Day, Year) Oct. 27, 1915 | | 9. Birthplace (State or Foreign Country) SC | | 10a. State Md. | | 10b. County n/a | | 10c. City, Town or Location Baltimore | | |
| 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number 4104 Ethland Avenue | | 10f. Zip Code 21207 | | 10g. Citizen of What Country? USA | | 10h. Usual Residence of Decedent | | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever In U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Black | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Collage (1-4 or 5+) 12th Grade | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Supervisor of BLDG. Operations | |
| 16b. Kind of Business/Industry Baltimore City Public Schools | | 17. Father's Name (First, Middle, Last) Thomas DuPree | | 18. Mother's Name (First, Middle, Maiden Surname) Cleatus Rogers | | 19a. Informant's Name/Relationship (Type, Print) Leanna M. Rogers wife | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4104 Ethland Avenue Baltimore, Md. 21207 | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Cedar Hill Cemetery | | 20c. Location - City or Town, State Anne Arundel, Md. | | 21. Signature of Funeral Service Licensee <i>[Signature]</i> | | 22. Name and Address of Facility Nutter Funeral Homes, Inc. 2501 Gwynns Falls PKWY Baltimore, Md. 21216 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Immediate Cause (Final disease or condition resulting in death) a. Acute Respiratory Distress Syndrome Due to (or as a consequence of): b. Sepsis Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | Approximate Interval Between Onset and Death 20 days 20 days | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and Title of certifier <i>[Signature]</i> | | 29c. License number 89276 | | 29d. Date signed (Month, Day, Year) 12/21/97 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rupinder Singh, M.D. 46 Maryland General Hospital | | 31. Date filed (Month, Day, Year) DEC 23 1997 | | 32. Registrar's Signature <i>[Signature]</i> | | 33. Registrar's Title Registrar | | 34. Registrar's License Number 6 | | 35. Registrar's Date DEC 23 1997 | |

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be completed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38757

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

FRANCES REMZI

2. Date of Death

Month Day Year
December 17, 1997

3. Time of Death

1910

4a. Facility Name (If not institution, give street and number)

Anne Arundel General Hospital

4b. City, Town, or Location of Death

Annapolis

4c. County of Death

Anne Arundel

5. Social Security Number

071-05-9409

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

78

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
June 3, 1919

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

Maryland

10b. County

Queen Anne

10c. City, Town or Location

Stevensville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

106 Nichols Manor Drive

10f. Zip Code

21666

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married

3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - if Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Secretary

16b. Kind of Business/Industry

Electric Company

17. Father's Name (First, Middle, Last)

Mehmet Walley

18. Mother's Name (First, Middle, Maiden Summa)

Caroline Sapilewski

19a. Informant's Name/Relationship (Type, Print)

Kerim Remzi - Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

15522 Yorktown Dr., Dumfries, VA 22026

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Pohick Cemetery

Date

12/20/97

20c. Location - City or Town, State

Lorton, Virginia

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Mountcastle Funeral Home

4143 Dale Blvd., Dale City, VA 22193

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cardiac arrest

Due to (or as a consequence of):

b. Coronary artery disease

Due to (or as a consequence of):

c. Cardiac valve disease

Due to (or as a consequence of):

d. Chronic leukemia

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

years

years

years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

congestive heart failure

h/o ulcer disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient

2 ☒ ER/Outpatient

3 ☐ DOA

Other:

4 ☐ Nursing Home

5 ☐ Residence

6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural

2 ☐ Accident

3 ☐ Suicide

4 ☐ Homicide

5 ☐ Pending investigation

6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Kathleen Hoy

29c. License number

D47627

29d. Date signed (Month, Day, Year)

12-18-97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Kathleen Hoy 2540 Centreville Road Centerville, MD 21617

31. Date filed (Month, Day, Year)

DEC 8 8 1997

32. Registrar's Signature

Johanna Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Permit: Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

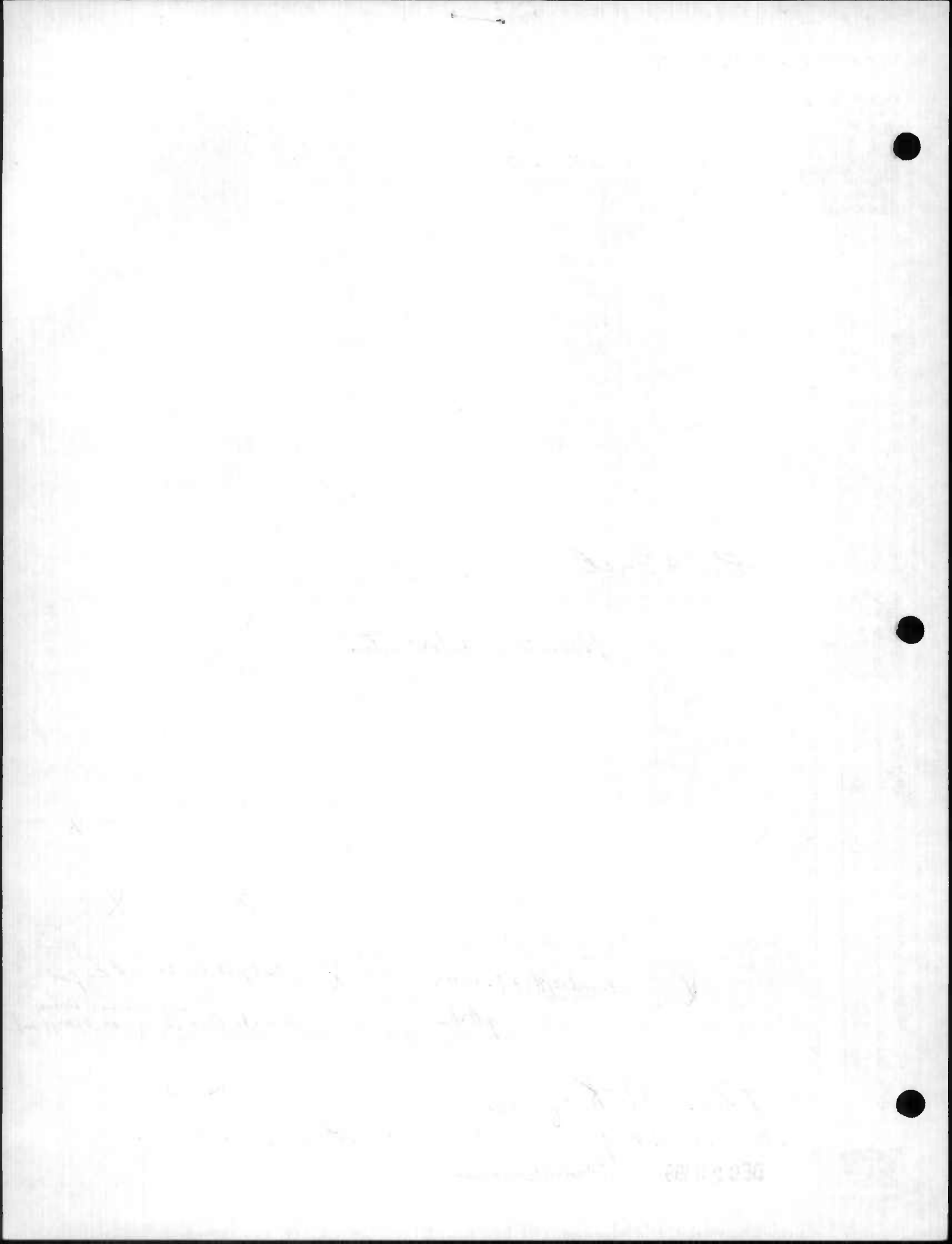
WRC
97-7110-510
UNK.97-266 STEVEN RUFF

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

Reg. No. 97 38758

| | | | | | | | | | | | | | | |
|---|---|---|---|--|--|---|--|--|--|---|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Steven Michael Ruff | | | | 2. Date of Death Month Day Year DEC. 09, 1997 | | 3. Time of Death 4:10 PM. | | | | | | | |
| | 4a. Facility Name (If not institution, give street and number) 200 ELLICOTT DR. LEAKIN PARK | | | | 4b. City, Town, or Location of Death BALTIMORE | | 4c. County of Death N/A | | | | | | | |
| Funeral Director | 5. Social Security Number 215-80-0539 | | 6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 32 Yrs. | | 8. Date of Birth (Month, Day, Year) OCT 5, 1965 | | 9. Birthplace (State or Foreign Country) Maryland | | | | | |
| | Usual Residence of Decedent | | | | | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State MD | | 10b. County N/A | | 10c. City, Town or Location Baltimore | | | | 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | |
| | 10e. Street and Number 3611 MacTavish Avenue | | | | 10f. Zip Code 21229 | | 10g. Citizen of What Country? USA | | | | | | | |
| | 11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | | | | | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Laborer | | | 16b. Kind of Business/Industry Plumbing | | | | | | |
| | 17. Father's Name (First, Middle, Last) Marvin Edward Ruff | | | | 18. Mother's Name (First, Middle, Maiden Surname) Judith Becker | | | | | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Judith Gibson/mother | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5911 Plumer Ave. Baltimore, MD 21206 | | | | | | | | | |
| | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Good Shepherd Cemetery 12/22/97 | | 20c. Location - City or Town, State Ellicott City, MD | | | | | | | |
| | 21. Signature of Funeral Service Licensee Edward A. Gregorchik | | | | 22. Name and Address of Facility MacNabb Funeral Home, P.A. 301 Frederick Rd. Baltimore, MD 21228 | | | | | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>Narcotic Intoxication</u> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | | Approximate Interval Between Onset and Death | | | |
| | Physician /Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | | | | |
| | | | | | | 24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | |
| 25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) LEAKIN PARK | | | | | | | | | | | | |
| 27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input checked="" type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) Found 12/9/97 1530 HR | | 28b. Time of Injury 1530 HR | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred Subject consumed drugs | | | | | | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) park | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) 200 ELLICOTT DR in Leakin Park Baltimore Maryland | | | | | | | | | | |
| 29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | 29c. License number O.C.M.E. | | 29d. Date signed (Month, Day, Year) DEC. 10, 1997 | | |
| 29b. Signature and title of certifier Theodore M. King | | | | | | | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) THEODORE M. KING 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 23 1997 | | | | | | | | | | 32. Registrar's Signature Julia Davidson-Randall | | | | |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38759

| | | | | | | | | | | |
|--|---|--|--|---|--|---|--------------------------------|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) EWALD | | | | 2. Date of Death Month December Day 18 Year 1997 | | | | 3. Time of Death 12²⁰ A | |
| | 4e. Facility Name (If not institution, give street and number) Stella Maris Hospice | | | | 4b. City, Town, or Location of Death Timonium | | | | 4c. County of Death Baltimore | |
| Funeral Director | 5. Social Security Number 217-36-3738 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 58 Yrs. | | If Under 1 Year Months Days | | If Under 24 Hrs. Hours Min. | |
| | 8. Date of Birth (Month, Day, Year) Oct. 27, 1939 | | 9. Birthplace (State or Foreign Country) New York | | Usual Residence of Decedent | | 10a. State Maryland | | 10b. County Baltimore | |
| 10c. City, Town or Location Baltimore | | 10d. inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number 5010 Bucks School House Road | | 10f. Zip Code 21237 | | 10g. Citizen of What Country? U.S.A. | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11th grade College (1-4or 5+) | | |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Automobile Mechanic | | 16b. Kind of Business/Industry Self-Employed Auto Mechanic | | 17. Father's Name (First, Middle, Last) Joachim Rambow | | 18. Mother's Name (First, Middle, Maiden Surname) Margaret Schlag | | 19. Informant's Name/Relationship (Type, Print) Mrs. Jeanne Rambow (wife) | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Forest Baptist Cemetery | | 20c. Location - City or Town, State 12/20/97 Upperco, Maryland | | 21. Signature of Funeral Service Licensee | | 22. Name and Address of Facility Schimunek Funeral Homes, Inc. 9705 Belair Rd., Baltimore, MD 21236 | | |
| 23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. Cirrhosis Due to (or as a consequence of): Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | 24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> EP/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) Hospice | | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | |
| 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | |
| 29b. Signature and Title of Certifier | | 29c. License number 15504 | | 29d. Date signed (Month, Day, Year) 12-18-97 | | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) DR. EDDIE NAKHODA 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 | | 31. Date filed (Month, Day, Year) DEC 23 1997 | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner


State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 38760

| | | | | | | | | |
|--|--|--|--|---|--|---------------------------------|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Nathaniel S. Robinson | | | | 2. Date of Death Month December Day 19 Year 1997 | | 3. Time of Death 6:30p | |
| | 4a. Facility Name (If not institution, give street and number) 1427 E. Federal St. | | | | 4b. City, Town, or Location of Death Baltimore | | 4c. County of Death n/a | |
| Funeral Director | 5. Social Security Number 226-38-9721 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 62 Yrs. | | 8. Date of Birth (Month, Day, Year) July 11, 1935 | |
| | 9. Birthplace (State or Foreign Country) VA | | 10a. State MD | | 10b. County n/a | | 10c. City, Town or Location Baltimore | |
| To Be Completed by Funeral Director | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | 10e. Street and Number 1427 E. Federal St. | | 10f. Zip Code 21213 | |
| | 10g. Citizen of What Country? USA | | | | 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | |
| | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: Black | | | | 14. Race - American Indian, Black, White, etc. Specify: Black | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10th College (14 or 5+) | |
| | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Laborer | | | | 16b. Kind of Business/Industry Bethlehem Steel | | | |
| | 17. Father's Name (First, Middle, Last) Rufus Robinson | | | | 18. Mother's Name (First, Middle, Maiden Surname) Evelyn Thompson | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Marjorie Robinson/wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1427 E. Federal St. Balto., MD 21213 | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Baltimore Cemetery | | 20c. Location - City or Town, State 12/24 Baltimore, MD | |
| | 21. Signature of Funeral Service Licensee  | | | | 22. Name and Address of Facility James A. Morton & Sons Funeral Home 1701 Laurens St. Balto., MD 21217 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) RECTAL CANCER Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 3 1/2 YEARS | | | | Approximate Interval Between Onset and Death 3 1/2 YEARS | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | | | 28a. Date of injury (Month, Day, Year) | | 28b. Time of Injury M | | |
| 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 28d. Describe how injury occurred | | | | |
| 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. Signature and title of Certifier  | | | | |
| 29c. License number D29071 | | | | 29d. Date signed (Month, Day, Year) 12-22-97 | | | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) R. KRISHNAN MD 84 N. EUTAW ST. #305 BALTIMORE MD 21201 | | | | 31. Date filed (Month, Day, Year) DEC 23 1997 | | | | |
| 32. Registrar's Signature  | | | | State Registrar | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21260-0760

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38761

| | | | | | | | | |
|--|--|--|---|--|---|--------------------------------|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Melvin Ray Saunders | | | | 2. Date of Death Month December Day 18 , Year 1997 | | 3. Time of Death 10:25pm | |
| | 4a. Facility Name (If not institution, give street and number) Greenspring Nursing & Rehabilitation | | | | 4b. City, Town, or Location of Death Baltimore | | 4c. County of Death City | |
| Funeral Director | 5. Social Security Number 214-64-1100 | | 8. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 41 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) April 23, 1956 | 9. Birthplace (State or Foreign Country) U.S. MD |
| | Usual Residence of Decedent | | | | | | | |
| To Be Completed by Funeral Director | 10a. State MD | | 10b. County Baltimore City | | 10c. City, Town or Location Baltimore | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| | 10e. Street and Number 1914 West North Avenue | | | | 10f. Zip Code 21217 | | 10g. Citizen of What Country? United States | |
| | 11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever In U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Black | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Laborer | | 16b. Kind of Business/Industry Construction | | | |
| | 17. Father's Name (First, Middle, Last) Vernon Lee Spratley Sr. | | | | 18. Mother's Name (First, Middle, Maiden Surname) Frances Saunders | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) Frances Saunders/mother | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1914 W. North Ave. Baltimore, MD 21217 | | | |
| | 20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory | | Date 12/20/97 | | 20c. Location - City or Town, State Baltimore | |
| | 21. Signature of Funeral Service Licensee <i>Vaughn C. Fung</i> | | | | 22. Name and Address of Facility Vaughn Green Funeral Services PA 5151 Baltimore National Pike | | | |
| | 23a. Pertinent disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last a. Anoxic encephalopathy Due to (or as a consequence of): b. Intravenous Drug Abuse Due to (or as a consequence of): c. Sinusitis Due to (or as a consequence of): d. Approximate Interval Between Onset and Death 1 month Unknown Unknown | | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Insulin Dependant Diabetes Mellitus | | | | | | | |
| State Registrar | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) | | | |
| | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. Describe how injury occurred | | | |
| | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | |
| | 29b. Signature and title of certifier Amatun N. Naem M.D. | | | | 29c. License number D 15503 | | 29d. Date signed (Month, Day, Year) December, 20, 1997 | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) AMATUN N. NAEEM, 501 DOLPHIN STREET, BALTIMORE MD 21217 | | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 23 1997 | | | | 32. Registrar's Signature <i>Julia Davidson-Randall</i> | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38762

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

CLAIRE VOLLMER SMITH

2. Date of Death

Month Day Year
12/17/1997

3. Time of Death

3:15 PM

4a. Facility Name (If not institution, give street and number)

5505 BOXHILL LANE

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

722-12-3127

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

73 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
08/08/1924

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

5505 BOXHILL LANE

10f. Zip Code

21210

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: WHITE

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12College (14 or 5+)
5+16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

FREDERICK C. VOLLMER

18. Mother's Name (First, Middle, Maiden Surname)

BERTHA ROSENBERGER

19a. Informant's Name/Relationship (Type, Print)

EUGENE P. SMITH/HUSBAND

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5505 BOXHILL LANE BALTIMORE, MD 21210

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)BALTIMORE WASHINGTON
CREMATORY

Date

12/20/97

20c. Location - City or Town, State

LAUREL, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

STERLING ASHTON FUNERAL HOME, INC.
736 EDMONDSON AVE. CATONSVILLE, MD 2122823. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. SEVERE DEBILITATION

Due to (or as a consequence of):

7 DAYS

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. METASTATIC MALIGNANCY TO LIVER AND BONE

Due to (or as a consequence of):

2 MONTHS

c. ADENOCARCINOMA OF COLON

Due to (or as a consequence of):

6 MONTHS

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CORONARY ARTERY INSUFFICIENCY

HYPERTENSION

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☒ Residence8 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Joseph D. Notarangelo M.D.

29c. License number

D07316

29d. Date signed (Month, Day, Year)

DECEMBER-18-1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JOSEPH D. NOTARANGELO M.D. 301 ST. PAUL PLACE - BALTIMORE MD 21202

31. Date filed (Month, Day, Year)

DEC 23 1997

32. Registrar's Signature

Joseph Gordon-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-1 show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38763

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Hellen B. Smyth

2. Date of Death

Dec. 19 1997

3. Time of Death

10:30 PM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

857 Padonia Rd.

4b. City, Town, or Location of Death

Cockeysville

4c. County of Death

Baltimore

5. Social Security Number

215-49-9614

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

46 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Dec 3 1951

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Cockeysville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

857 Padonia Rd.

10f. Zip Code

21030

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever In U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12 yrs.

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

homemaker

16b. Kind of Business/Industry

home

17. Father's Name (First, Middle, Last)

unknown

18. Mother's Name (First, Middle, Maiden Surname)

Frances Gould

19a. Informant's Name/Relationship (Type, Print)

Robert L. Smyth Jr.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

857 Padonia Rd. Cockeysville, Maryland 21030

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Green Mount Cemetery

Date

Dec 22 1997

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Kersta J. Wells

22. Name and Address of Facility

Evans Funeral Chapel
2325 York Rd. Timonium, Maryland 21093

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Melanoma

a. Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Yrs

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Kersta J. Wells

29c. License number

D23076

29d. Date signed (Month, Day, Year)

12-20-97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

RICHARD L. JAMON

3730 Falls Rd. Balt Md

State
Registrar

31. Date filed (Month, Day, Year)

DEC 23 1997

32. Registrar's Signature

Julia Davidson-Randall

2121

Baltimore, Maryland 21215-0020

Permit: Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38764

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Luke Shaw

2. Date of Death

Month Day Year
December 20 1997

3. Time of Death

6:17 PM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

SINAI HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

n/a

5. Social Security Number

220-22-2375-A

6. Sex

M 2 F

7. Age (In yrs. last birthday)

69

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Aug. 16, 1928

9. Birthplace (State or Foreign Country)

N.C.

Usual Residence of Decedent

10a. State

Md.

10b. County

n/a

10c. City, Town, or Location

Baltimore

10d. Inside City Limits

Yes 2 No

10e. Street and Number

6220 Liberty Heights Avenue

10f. Zip Code

21207

10g. Citizen of What Country?

USA

11. Marital Status

1 Never Married 2 Married
3 Widowed 4 Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 Yes 2 No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 No Specify:

14. Race - American Indian,
Black, White, etc.

Specify: Black

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

5

College (1-4 or 5+)

16e. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Art History Professor

16b. Kind of Business/Industry

Coppin State University

17. Father's Name (First, Middle, Last)

Frank Willie Shaw

18. Mother's Name (First, Middle, Maiden Surname)

Bessie Sutton

19a. Informant's Name/Relationship (Type, Print)

Virginia L. Shaw wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6220 Liberty Heights Terrace Balto., Md. 21207

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Shaw Family Cemetery

Date

Dec. 28

20c. Location - City or Town, State

Kenly, NC.

21. Signature of Funeral Service Licensee

Robert E. Nutter

22. Name and Address of Facility

Nutter Funeral Homes, Inc.
2501 Gwynns Falls PKWY Baltimore, Md. 2121623a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Multi-organ failure

48 hrs

Due to (or as a consequence of):

b. Acute myocardial Infarction

48 hrs

Due to (or as a consequence of):

c. Coronary Artery Disease

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy
performed?

1 Yes 2 No

24b. Were autopsy findings
available prior to
completion of cause
of death?

1 Yes 2 No

25. Was case referred to medical
examiner?
1 Yes 2 No

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death

1 Natural 2 Accident 3 Suicide 4 Homicide
5 Pending Investigation
6 Could not be determined28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury at
Work?
1 Yes 2 No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Resident Physician

29c. License number

AS 2402321-GA-9063

29d. Date signed (Month, Day, Year)

December 20, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

GIL ALLEN, MD, SINAI HOSPITAL, BALTIMORE, MD

31. Date filed (Month, Day, Year)

DEC 23 1997

32. Registrar's Signature

Julia Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

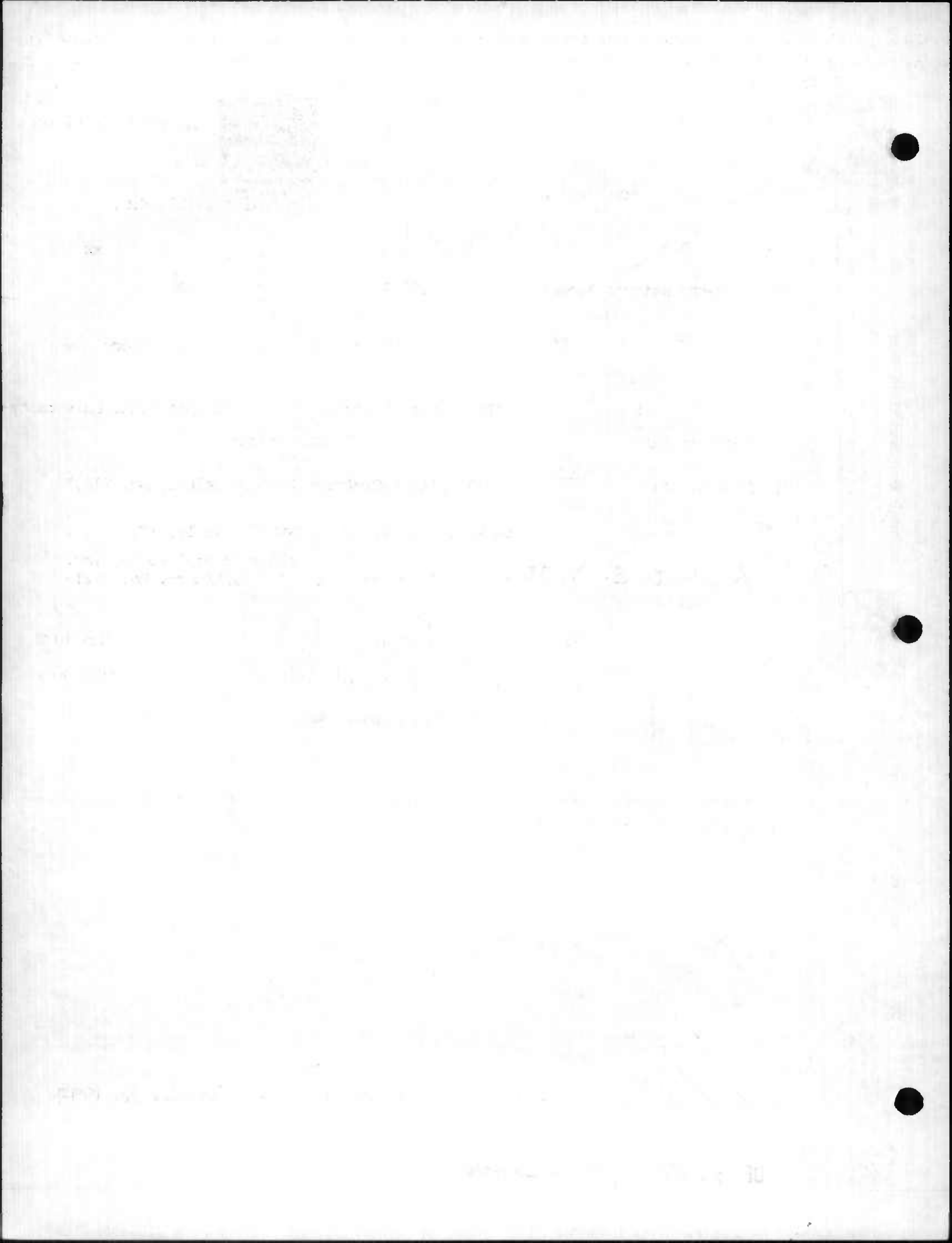
Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or item 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38765

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Ethyl Jean Stump

2. Date of Death

Month Day Year
December 6, 1997

3. Time of Death

7:15am

4a. Facility Name (If not institution, give street and number)

Livingston Health Care Center

4b. City, Town, or Location of Death

Fort Washington

4c. County of Death

Prince George's

Funeral
Director

5. Social Security Number

481-58-6794

6. Sex

1 ☐ M 2 ☒ F

7. Age (in yrs. last birthday)

89 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Jan. 22, 1908

9. Birthplace (State or Foreign Country)

MO

Usual Residence of Decedent

10a. State

Maryland

10b. County

Charles

10c. City, Town or Location

Bryans Road

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

5720 Penguin Place

10f. Zip Code

20616

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

1

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

George Murphy

18. Mother's Name (First, Middle, Maiden Surname)

Nellie Conway

19a. Informant's Name/Relationship (Type, Print)

Sandra Bauer/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5720 Penguin Place Bryans Road, MD 20616

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

The Sand Cemetery

Date

12/11/97

20c. Location - City or Town, State

St. Francesville, MO

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Ives-Pearson Funeral Homes
2847 Wilson Blvd. Arlington, VA 22201

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Pneumonia

Approximate Interval Between Onset and Death

3 Days

Due to (or as a consequence of):

Inability to Swallow

2 weeks

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

28. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28e. Date of Injury (Month, Day Year)

28f. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

3 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and Title of certifier

29c. License number

D 26 352

29d. Date signed (Month, Day, Year)

Dec 6 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

O. Haye 9131 Piscataway Rd. Clinton, MD 20735

31. Date filed (Month, Day, Year)

DEC 23 1997

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Dec 2 1991

Dec 2 1991

Administrative

Dec 2 1991

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 38766

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Thelma

Sites

2. Date of Death

Month Day Year
December 20, 1997

3. Time of Death

7:13 am

4a. Facility Name (If not institution, give street and number)

Johns Hopkins Bayview Medical Ctr.

4b. City, Town, or Location of Death

Baltimore City

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

203-01-2238

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

78

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Jan. 14, 1919

9. Birthplace (State or Foreign Country)

Kentucky

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Dundalk

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1730 Drexel Road

10f. Zip Code

21222

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
9 Years

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Factory Worker Assembler

16b. Kind of Business/Industry

Factory

17. Father's Name (First, Middle, Last)

Landon Hutson

18. Mother's Name (First, Middle, Maiden Surname)

Callie Arnold

19a. Informant's Name/Relationship (Type, Print)

Mr. Charles E. Sites/Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1730 Drexel Road Dundalk, Maryland 21222

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Oak Lawn Cemetery 12/23/1997

Date

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Patrick M. Fleming

22. Name and Address of Facility

Duda-Ruck Funeral Home of Dundalk, Inc.

7922 Wise Ave. Dundalk, Maryland 21222

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

e. Respiratory arrest

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

10 mins

b. metabolic lactic acidosis

Due to (or as a consequence of):

6 hours

c. mesenteric ischemia

Due to (or as a consequence of):

6 hours

d. peripheral vascular disease

10 yrs

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Coronary artery disease, hypertension,

Congestive heart failure

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation
6 ☐ Could not be determined28a. Date of Injury
(Month, Day, Year)28b. Time of
injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Thomas R. Talbot III MD

29c. License number

RES - 000

29d. Date signed (Month, Day, Year)

12/20/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Tom R. Talbot 1000 E. Eager St. Baltimore, MD

31. Date filed (Month, Day, Year)

DEC 23 1997

32. Registrar's Signature

John Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Item: 18 Per Fh Film G-754 12-23-97RC

Certificate of Death

Reg. No.

97 38767

| | | | | | | | | | | | | | | |
|--|--|--|---|--|--|--|---------------------------------|--|--|--|--|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) HELEN STRYHN | | | | 2. Date of Death Month DEC Day 22 Year 97 | | | | 3. Time of Death 0359A | | | | | |
| | 4a. Facility Name (If not institution, give street and number) Carroll County General Hospital | | | | 4b. City, Town, or Location of Death Westminster | | | | 4c. County of Death Carroll | | | | | |
| Funeral Director | 5. Social Security Number 220-18-7830 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 77 Yrs. | | If Under 1 Year Months Days | | If Under 24 Hrs. Hours Min. | | 8. Date of Birth (Month, Day, Year) Sept. 3 1920 | | 9. Birthplace (State or Foreign Country) Illinois | |
| | Usual Residence of Decedent | | | | | | | | | | | | | |
| To Be Completed by Funeral Director | 10e. State MD | | 10b. County Carroll | | 10c. City, Town or Location Hampstead | | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| | 10e. Street and Number 895 Century St. | | | | 10f. Zip Code 21074 | | | | 10g. Citizen of What Country? USA | | | | | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: White | | | | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 1 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker | | | | 16b. Kind of Business/Industry Own Home | | | | | |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last) Julius Petersen | | | | 18. Mother's Name (First, Middle, Maiden Surname) Anna Frederickson Anna Fredericksen | | | | | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Ottar Stryhn/husband | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 895 Century St., Hampstead, MD 21074 | | | | | | | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Dulaney Valley Memorial Gardens | | | | Date 12/24/97 | | 20c. Location - City or Town, State Timonium, MD 21093 | | | |
| | 21. Signature of Funeral Service Licensee Bryan W. Clary | | | | 22. Name and Address of Facility Lemmon Funeral Home 10 W. Padonia Rd., Timonium, MD 21093 | | | | | | | | | |
| Physician /Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. e. COMPLETE HEART BLOCK Due to (or as a consequence of): 2 HRS b. POSSIBLE MYOCARDIAL INFARCTION Due to (or as a consequence of): 2 HRS c. Due to (or as a consequence of): d. | | | | | | | | | | | | | |
| | 23b. Part II. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | | |
| | 23c. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | | | | | | | | | |
| | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | | |
| | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. Signature and title of certifier Hafiez A. Syed M.D. | | | | 29c. License number 025052 | | | | 29d. Date signed (Month, Day, Year) 12/22/97 | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HAFIEZ A SYED 20 CROSSROADS Dr OWINGS MILLS 21117 | | | | | | | | | | | | | |
| State Registrar | 31. Date filed (Month, Day, Year) DEC 23 1997 | | | | 32. Registrar's Signature John Davidson-Randall | | | | | | | | | |

100-100000-100000

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38768

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Robert Sloan, Jr.

2. Date of Death

Month Day Year
December 21, 1997

3. Time of Death

7:20pm

4a. Facility Name (If not institution, give street and number)

17200 Whitely Road

4b. City, Town, or Location of Death

Monkton

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

078-10-4471

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

86

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
April 13, 1911

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Monkton

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

17200 Whitely Road

10f. Zip Code

21111

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married

3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Chief Executive Officer

16b. Kind of Business/Industry

Transit

17. Father's Name (First, Middle, Last)

Robert Sloan

18. Mother's Name (First, Middle, Maiden Summa)

Isabelle Orr

19a. Informant's Name/Relationship (Type, Print)

Dorothy E. Sloan/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

17200 Whitely Road, Monkton, Maryland 21111

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Fleck Crematory

Date

12/23/97

20c. Location - City or Town, State

Laurel, Maryland

21. Signature of Funeral Service Licensee

Bryan W. Clary

22. Name and Address of Facility

Lemmon Funeral Home

10 W. Padonia Road, Timonium, Maryland 21093

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. LYMPHOMA (MANTLE CELL)

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

4 1/2 YEARS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural

2 ☐ Accident

3 ☐ Suicide

4 ☐ Homicide

5 ☐ Pending investigation

6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Eric J. Seifter

29c. License number

D 29373

29d. Date signed (Month, Day, Year)

December 22, 1997

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

ERIC J. SEIFTER, MD 10755 FALLS RD, SUITE 200 LUTHERVILLE, MD 21093

31. Date filed (Month, Day, Year)

DEC 23 1997

32. Signature of Registrar

J. Davidson-Pondale

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38769

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last) **Lydia Salamone** 2. Date of Death Month **December** Day **19** Year **1997** 3. Time of Death **8:15 pm**

4a. Facility Name (If not institution, give street and number)

Liberty Medical Center

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral
Director

5. Social Security Number
212-18-2771

6. Sex ☐ M ☒ F

7. Age (In yrs. last birthday) Yrs. **77**

If Under 1 Year Months Days

If Under 24 Hrs. Hours Min.

8. Date of Birth (Month, Day, Year)
Nov. 28, 1920

9. Birthplace (State or Foreign Country)
Maryland

Usual Residence of Decedent

10a. State

Baltimore

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

2117 Denison St.

10f. Zip Code

21216

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☐ Married
☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: **White**

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12th grade

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Beautician

16b. Kind of Business/Industry

Beauty Shop

17. Father's Name (First, Middle, Last)

Coy H. Condon

18. Mother's Name (First, Middle, Maiden Surname)

Names Unknown

19a. Informant's Name/Relationship (Type, Print)

S. Donald Salamone (son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3911 Pinedale Drive, Baltimore, MD 21236

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Druid Ridge Cemetery

Date

12/22/97 Baltimore, Maryland

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

**Schimunek Funeral Homes, Inc.
9705 Belair Rd., Baltimore, MD 21236**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. **Cerebrovascular Accident**

Approximate Interval Between Onset and Death

unknown

Due to (or as a consequence of):

b. **Chronic obstructive Pulmonary Disease**

unknown

Due to (or as a consequence of):

c. **Diabetes Mellitus**

unknown

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Atherosclerotic Cardiovascular Disease

Schizophrenia

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☐ Probably ☒ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?
☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☒ Inpatient

☐ ER/Outpatient

☐ DOA

Other:

☐ Nursing Home

☐ Residence

☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Accident ☐ Suicide ☐ Homicide
☐ Pending investigation ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?
☐ Yes ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Medical Examiner

29b. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

[Signature]

29c. License number

D33583

29d. Date signed (Month, Day, Year)

December 19, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Halter Zrebeck LMC

**2606 Liberty Heights Ave
Baltimore, MD 21215**

31. Date filed (Month, Day, Year)

DEC 23 1997

32. Registrar's Signature

[Signature]

State
Registrar

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

FRANK DELBERT SHORT JR

State of Maryland / Department of Health and Mental Hygiene

Items: 23 part 1, 27, 28a-f per MEQ G-755

1/5/98 meb
Certificate of Death

Reg. No.

97 38770

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician
/Medical
Examiner

Funeral
Director

| | | | | | | | |
|---|--|--|--|--|--|---|---|
| 1. Decedent's Name (First, Middle, Last) Frank Delbert Short, Jr. | | | | 2. Date of Death Month Day Year DEC. 15, 1997 | | 3. Time of Death 10:27 AM | |
| 4a. Facility Name (If not institution, give street and number) WASHINGTON COUNTY HOSPITAL | | | | 4b. City, Town, or Location of Death HAGERSTOWN | | 4c. County of Death WASHINGTON | |
| 5. Social Security Number 065-46-3119 | | 6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 43 Yrs. | | 8. Date of Birth (Month, Day, Year) May 04, 1954 | |
| 9. Birthplace (State or Foreign Country) New York | | 10a. State WV | | 10b. County Jefferson | | 10c. City, Town or Location Harpers Ferry | |
| 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 10e. Street and Number 77 Hawthorne Drive-Shannondale | | 10f. Zip Code 25425 | | 10g. Citizen of What Country? U.S.A. | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 1972-1974 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Construction Worker | | 16b. Kind of Business/Industry Construction CO. | | | |
| 17. Father's Name (First, Middle, Last) Frank D. Short | | | | 18. Mother's Name (First, Middle, Maiden Surname) Janice Miller | | | |
| 19a. Informant's Name/Relationship (Type, Print) Marilyn F. Short-Wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RR#04, Box 156, Harpers Ferry, WV 25425 | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Union Cemetery | | 20c. Location - City or Town, State 12/19/97 Leesburg, VA | | | |
| 21. Signature of Funeral Service Licensee D. S. Christa | | | | 22. Name and Address of Facility Melvin T. Strider Co., Inc. P.O. Box 388, Charles Town, WV 25414 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) EPHEDRINE INTOXICATION a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | Approximate Interval Between Onset and Death |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |
| 24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |
| 25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input checked="" type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) 12/15/97 | | 28b. Time of Injury unknown M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| 28d. Describe how injury occurred UNKNOWN | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) UNKNOWN | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) UNKNOWN | | | |
| 29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| 29b. Signature and title of certifier O.C.M.E. | | | | 29c. License number O.C.M.E. | | 29d. Date signed (Month, Day, Year) DEC. 16, 1997 | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) J. L. R. W. Locke, MD 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 2, 1997 | | 32. Registrar's Signature J. Davidson-Randall | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

38771

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

MATTIE LOU STUKES

2. Date of Death

Month Day Year
DECEMBER 15 1997

3. Time of Death

15:45

4a. Facility Name (If not institution, give street and number)

UNION MEMORIAL HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/a

Funeral
Director

5. Social Security Number

215-12-8148

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

79 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
AUG. 15, 1918

9. Birthplace (State or Foreign Country)

SOUTH CAROLINA

Usual Residence of Decedent

10a. State
Maryland10b. County
n/a

10c. City, Town or Location

BALTIMORE CITY

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

1914 E. 31ST STREET

10f. Zip Code

21218

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever In U.S.

Armed Forces?

1 ☐ Yes 2 ☐ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: NEGRO

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

4TH

Collage (1-4 or 5+)

N/A

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

LINE PERSON

16b. Kind of Business/Industry

SHAPOPIROSE AND SONS
FACTORY

17. Father's Name (First, Middle, Last)

CHARLIE CONYERS

18. Mother's Name (First, Middle, Maiden Surname)

JANIE

19a. Informant's Name/Relationship (Type, Print)

MADLENE WASHINGTON-granddaughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10 COMILL COURT, OWINGS MILLS, MD. 21117

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

WESTERN STAR CEM DEC. 19, 1997

Date

20c. Location - City or Town, State

BALTO, MD.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

CALVIN B. SCRUGGS FUNERAL HOME

1412 E. PRESTON STREET BALTO, MD. 21213

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. DEHYDRATION

Due to (or as a consequence of):

3 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. ANOREXIA

Due to (or as a consequence of):

1 week

c. END STAGE CARDIOMYOPATHY

Due to (or as a consequence of):

3 years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CONGESTIVE HEART FAILURE -

ANEMIA - PICHINUS SYNDROME -

Hypertension.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

☒ Inpatient2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

2 ☒ Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D41637

29d. Date signed (Month, Day, Year)

DEC 16 / 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

SALIM I RIZK, MD

UNION MEMORIAL HOSP

31. Date filed (Month, Day, Year)

DEC 23 1997

32. Registrar's

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1951 1001 21 23043041 2001 1001 21 23043041

1951 1001 21 23043041 2001 1001 21 23043041

1951 1001 21 23043041 2001 1001 21 23043041

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38772

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Theresa C. Singer

2. Date of Death

Month Day Year
12 17 97

3. Time of Death

1035

4a. Facility Name (If not institution, give street and number)

8147 Main Creek Road

4b. City, Town, or Location of Death

Pasadena, MD

4c. County of Death

Anne-Arundel

Funeral
Director

5. Social Security Number

214-44-2102

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

53 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
March 5, 1944

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Anne-Arundel

10c. City, Town or Location

Pasadena, Maryland

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8147 Main Creek Road

10f. Zip Code

21122

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married

3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

9th grade

College (1-4 or 5+)

N/A

18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

William Seibel

18. Mother's Name (First, Middle, Maiden Surname)

Mary Helen Hanokovicz

19a. Informant's Name/Relationship (Type, Print)

Elmo J. Singer / Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8147 Main Creek Road Baltimore MD 21122

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☒ Other (Specify) Mausoleum

20b. Place of Disposition (Name of cemetery, crematory or other place)

Cedar Hill Cemetery

December 23, 1997

Date

20c. Location - City or Town, State

Baltimore Maryland

21. Signature of Funeral Service Licensee Victor P. Doda, Jr.

[Signature]

22. Name and Address of Facility

Charles L. Stevens Funeral Home, Inc.

1501 East Fort Avenue, Baltimore Maryland 21230

23a. Part I. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Acute Cardiac Insufficiency

Due to (or as a consequence of):

b. Hypertensive Heart Disease

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home

5 ☒ Residence

6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural

2 ☐ Accident

3 ☐ Suicide

4 ☐ Homicide

5 ☐ Pending Investigation

6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Location (Street and Number or Rural Route Number, City or Town, State)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature] Deputy

29c. License number

D 06054

29d. Date signed (Month, Day, Year)

12/22/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

William P. Jones, MD

695 America 21035

31. Date filed (Month, Day, Year)

DEC 23 1997

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be completed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38773

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician / Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be procured within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician / Medical Examiner

Funeral Director

| | | | | | |
|--|--|---|--------------------------------|--|---|
| 1. Decedent's Name (First, Middle, Last) ROSE M. SAIERSKI | | 2. Date of Death Month Day Year DECEMBER 2, 1997 | | 3. Time of Death 9:00PM | |
| 4a. Facility Name (If not institution, give street and number) HOPKINS BAY VIEW HOSPITAL | | 4b. City, Town, or Location of Death BALTIMORE | | 4c. County of Death N/A | |
| 5. Social Security Number 213-16-9960 | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 84 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) MARCH 27, 1913 |
| 9. Birthplace (State or Foreign Country) PA. | | | | | |
| Usual Residence of Decedent | | | | | |
| 10a. State MARYLAND | | 10b. County N/A | | 10c. City, Town or Location BALTIMORE | |
| 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | |
| 10e. Street and Number 202 N. ELLWOOD AVENUE | | 10f. Zip Code 21224 | | 10g. Citizen of What Country? USA | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | |
| 14. Race - American Indian, Black, White, etc. Specify: WHITE | | | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6 YEARS | | College (1-4 or 5+) HOMEMAKER | | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) OWN HOME | |
| 17. Father's Name (First, Middle, Last) ANTONIO RUFFO | | 18. Mother's Name (First, Middle, Maiden Surname) PHILAMINA JANNELLI | | | |
| 19a. Informant's Name/Relationship (Type, Print) MR. FRANK SAIERSKI | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 629 S. ELLWOOD AVE. BALTO. MD. 21224 | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) ST. STANISLAUS CEM. | | 20c. Location - City or Town, State 12-6-97 BALTO. MD. | |
| 21. Signature of Funeral Service Licensee <i>Charles R. Kaczorowski</i> | | 22. Name and Address of Facility KACZOROWSKI FUNERAL HOME 1201 DUNDALK AVE. BALTO. MD. 21222 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. CARDIAC ARREST Due to (or as a consequence of): b. MITRAL VALVE REGURGITATION Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | Approximate Interval Between Onset and Death 1 HR. 5 YRS. | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | |
| 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | |
| | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. Certifier (Check only one) 2 <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier <i>Roger S. Blumenthal</i> | | | |
| | | 29c. License number D34516 | | 29d. Date signed (Month, Day, Year) DECEMBER 5, 1997 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ROGER S. BLUMENTHAL, MD. CARNEGIE 538 600 N. WOLFE ST. BALTO. MD. 21287 | | | | | |
| 31. Date filed (Month, Day, Year) DEC 23 1997 | | 32. Registrar's Signature <i>Julia Davidson-Ponder</i> | | | |

State Registrar

Handwritten signature

100-1000

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38774

| | | | | | | | | |
|---|--|-----------------------------|---|---|---|--|--|---|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Edith Irene Sporny | | | | 2. Date of Death Month Day Year December 20, 1997 | | 3. Time of Death 6:10 P.M. | |
| | 4a. Facility Name (If not institution, give street and number) 202 Hawthorne Road | | | | 4b. City, Town, or Location of Death Linthicum | | 4c. County of Death Anne Arundel | |
| Funeral Director | 5. Social Security Number 213-36-4370 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 83 Yrs. | | 8. Date of Birth (Month, Day, Year) Nov. 18, 1914 | |
| | 9. Birthplace (State or Foreign Country) Maryland | | | | | | | |
| Usual Residence of Decedent | | | | | | | | |
| 10a. State Maryland | | 10b. County Anne Arundel | | 10c. City, Town or Location Linthicum | | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| 10e. Street and Number 202 Hawthorne Road | | | | 10f. Zip Code 21090 | | 10g. Citizen of What Country? United States | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker | | | 16b. Kind of Business/Industry Own Home | | |
| 17. Father's Name (First, Middle, Last) James Feast | | | | 18. Mother's Name (First, Middle, Maiden Surname) Alice Pole | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Melvin Sporny/Husband | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 202 Hawthorne Road Linthicum, MD 21090 | | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Glen Haven Mem. Pk. | | Date December 23, 1997 | | 20c. Location - City or Town, State Glen Burnie, MD | |
| 21. Signature of Funeral Service Licensee <i>[Signature]</i> | | | | 22. Name and Address of Facility Kirkley-Ruddick Funeral Home 421 Crain Hwy. S.E. Glen Burnie, MD 21061 | | | | |
| 23a. Part I. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Congestive Heart Failure Due to (or as a consequence of): Atherosclerotic Cardiovascular Disease Due to (or as a consequence of): Diabetes Mellitus - Type II Due to (or as a consequence of): Breast Cancer | | | | | | | | Approximate Interval Between Onset and Death 2yrs. 10yrs. 5yrs. 2yrs. |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | | | 28d. Describe how injury occurred | | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | 29b. Signature and title of certifier <i>[Signature]</i> | | | 29c. License number D396160 | | 29d. Date signed (Month, Day, Year) December 22, 1997 |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Robert Dart 901 East Fort Ave. Baltimore, MD 21230 | | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 23 1997 | | | 32. Registrar's Signature <i>[Signature]</i> | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38775

| | | | | | | | | |
|--|--|---|---|---|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) ETHEL L. Sisson | | | | 2. Date of Death Month Day Year DEC 19, 1997 | | 3. Time of Death 2:20 AM | |
| | 4a. Facility Name (If not institution, give street and number) Forest Haven Nursing Home | | | | 4b. City, Town, or Location of Death Baltimore | | 4c. County of Death Baltimore | |
| Funeral Director | 5. Social Security Number 213-09-6671 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 83 Yrs. | 8. Date of Birth (Month, Day, Year) July 18, 1914 | | 9. Birthplace (State or Foreign Country) Carroll Co. Md. | |
| | 10a. State Md. | | 10b. County City | | 10c. City, Town or Location Baltimore | | 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| To Be Completed by Funeral Director | 10e. Street and Number 1003 Wedgewood Road | | | | 10f. Zip Code 21229 | | 10g. Citizen of What Country? USA | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Collage (1-4or 5+) 8 th | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Housewife | | 16b. Kind of Business/Industry Own Home | | | |
| | 17. Father's Name (First, Middle, Last) Kinsey Taylor | | | | 18. Mother's Name (First, Middle, Maiden Sumama) Nettie Hughes | | | |
| | 19a. Informant's Name/Relationship (Type, Print) William N. Sisson (Husband) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1003 Wedgewood Rd. Baltimore, Md. 21229 | | | |
| | 20a. Method of Disposition XX Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Meadowridge Memorial | | 20c. Location - City or Town, State Howard C. Md. | | 20d. Date 12/22/97 | |
| | 21. Signature of Funeral Service Licensee <i>Sam B. Elini</i> | | | | 22. Name and Address of Facility ELINE FUNERAL HOME 11824 Reisterstown Road Reisterstown, Md. 21136 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. Cerebral Thrombosis Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | | | | | |
| | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CHRONIC ATRIAL FIBRILLATION PARKINSONS DISEASE | | | | | | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| 29b. Signature and title of certifier <i>Tasneem Lakhani</i> | | | | 29c. License number D 28595 | | 29d. Date signed (Month, Day, Year) 12/19/97 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TASNEEM LAKHANI, 7220 PARK HEIGHTS AVE BALTO MD 21208 | | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 23 1997 | | 32. Registrar's Signature <i>John F. Gordon-Randall</i> | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 38776

Item #19a per FH 12/24/97 EW

Certificate of Death

Reg. No.

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

HARRY

STERN

2. Date of Death
Month Day Year

December 16 1997

3. Time of Death

10³⁰ pm

4a. Facility Name (If not institution, give street and number)

SINAI HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

5. Social Security Number

216-09-1589

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

90 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth
(Month, Day, Year)

APR. 4, 1907

9. Birthplace (State or Foreign Country)

PENNSYLVANIA

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2500 W. BELVEDERE AVE., APT. 205

10f. Zip Code

21215

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever In U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

CABINET MAKER

16b. Kind of Business/Industry

FURNITURE

17. Father's Name (First, Middle, Last)

PHILLIP

STERN

18. Mother's Name (First, Middle, Maiden Surname)

ANNA

GAYLOR

19a. Informant's Name Relationship (Type, Print)

Mrs. Elaine Herlocker (Niece)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1615 SHAKESPEARE ST. BALTO., MD 21231

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

AHAVAS SHALOM AGUDAS ACHIM ANSHE SFARD ROSEDALE, MD

12/18/97

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Scott M. Cutler

22. Name and Address of Facility

SOL LEVINSON & BROS., INC.

8900 REISTERSTOWN RD., PIKESVILLE, MD 21208

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Pneumonia
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Neutropenia
Due to (or as a consequence of):

months

c. Bacteremia
Due to (or as a consequence of):

days

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

coronary artery disease, hypertension, urinary tract infection

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined28a. Date of Injury
(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Christopher J. Davis

29c. License number

A52402321 CO-9524

29d. Date signed (Month, Day, Year)

December 16 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Christopher J. Davis 2401 West Belvedere Avenue

31. Date filed (Month, Day, Year)

DEC 23 1997

32. Registrar's Signature

Julia Davidson-Randall

State
Registrar

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Name Harry Stern

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

THE UNITED STATES OF AMERICA
DEPARTMENT OF THE INTERIOR
BUREAU OF LAND MANAGEMENT
WASHINGTON, D. C. 20250

TO: [illegible]
FROM: [illegible]
SUBJECT: [illegible]

1. [illegible]
2. [illegible]
3. [illegible]
4. [illegible]
5. [illegible]

6. [illegible]
7. [illegible]
8. [illegible]
9. [illegible]
10. [illegible]

11. [illegible]
12. [illegible]
13. [illegible]
14. [illegible]
15. [illegible]

16. [illegible]
17. [illegible]
18. [illegible]
19. [illegible]
20. [illegible]

21. [illegible]
22. [illegible]
23. [illegible]
24. [illegible]
25. [illegible]

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

Reg. No.

97 38777

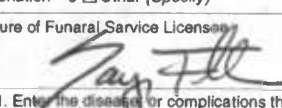
Baltimore, Maryland 21215-0020

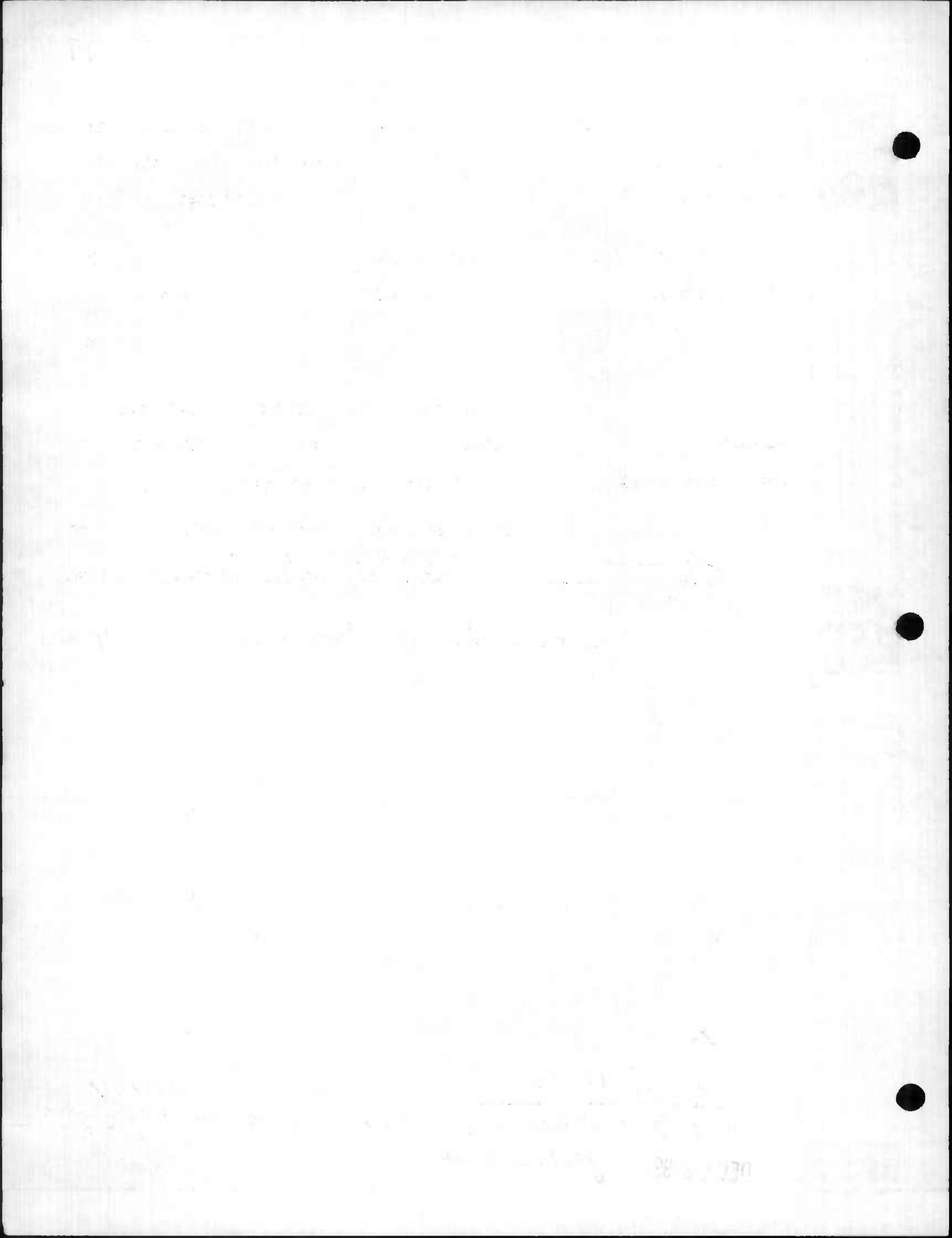
Division of Vital Records, P.O. Box 68799

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

| | | | | | | | |
|---|--|---|---|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Nema (First, Middle, Last) ALAN JACOB SUGAR | | | | 2. Date of Death Month DEC. Day 18 Year 1997 | | 3. Time of Death 6:10 PM |
| | 4a. Facility Name (If not institution, give street and number) 3718 NORBURN RD. | | | | 4b. City, Town, or Location of Death RANDALLSTOWN | | 4c. County of Death BALTIMORE |
| Funeral Director | 5. Social Security Number 218-40-6630 | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 54 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) DEC. 26, 1942 | 9. Birthplace (State or Foreign Country) MARYLAND |
| | Usual Residence of Decedent | | | | | | |
| To Be Completed by Funeral Director | 10a. State MD | 10b. County BALTIMORE | 10c. City, Town or Location RANDALLSTOWN | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| | 10e. Street and Number 3718 NORBURN RD. | | | 10f. Zip Code 21133 | | 10g. Citizen of What Country? USA | |
| | 11. Marital Status <input type="checkbox"/> Navar Marriad <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: WHITE |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 2 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) CUSTOMER SERVICE ENGINEER | | 16b. Kind of Business/Industry XEROX CORP. | | |
| | 17. Father's Name (First, Middle, Last) MARSHALL SUGAR | | | 18. Mother's Name (First, Middle, Maiden Surname) ANNA SCHWARTZ | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) DORIS SUGAR (WIFE) | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3718 NORBURN RD. RANDALLSTOWN, MD 21133 | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cramation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) BETH EL MEM. PARK | | Date 12/21/97 | 20c. Location - City or Town, State RANDALLSTOWN, MD | |
| | 21. Signature of Funeral Service Licensee  | | | 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN RD., PIKESVILLE, MD 21208 | | | |
| | 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <div style="display: flex; align-items: center;"> <div style="font-size: 4em; margin-right: 10px;">{</div> <div> <p>a. Carcinoma of Pancreas Due to (or as a consequence of):</p> <p>b. Cancer cachexia, Liver metastases Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p> </div> </div> | | | | | | Approximate Interval Between Onset and Death 11 mos |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier  M.S. DIDOLKAR MD | | | | | |
| 29c. License number DO 22105 | | 29d. Date signed (Month, Day, Year) 12/19/97 | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.S. DIDOLKAR MD Sinai Hospital Baltimore MD 21215 | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 23 1997 | | 32. Registrar's Signature  | | | | | |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38778

| | | | | | | | | |
|---|--|--|---|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Wanda C. Swearingen | | | | 2. Date of Death Month Day Year Dec. 17, 1997 | | 3. Time of Death 10:15pm | |
| | 4a. Facility Name (If not institution, give street and number) 1000 Franklin Ave. Apt. 1107 | | | | 4b. City, Town, or Location of Death Essex | | 4c. County of Death Baltimore | |
| Funeral Director | 5. Social Security Number 579-28-6788 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 72 Yrs. | | 8. Date of Birth (Month, Day, Year) July 17, 1925 | |
| | 9. Birthplace (State or Foreign Country) W. Virginia | | 10a. State Md. | | 10b. County Baltimore | | 10c. City, Town or Location Essex | |
| To Be Completed by Funeral Director | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 10e. Street and Number 1000 Franklin Ave. Apt. 1107 | | 10f. Zip Code 21221 | | 10g. Citizen of What Country? USA | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: white | |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8th | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Housewife | | 16b. Kind of Business/Industry own home | | | |
| | 17. Father's Name (First, Middle, Last) Ocil W. Barnes | | 18. Mother's Name (First, Middle, Maiden Surname) Lora | | 19. Informant's Name/Relationship (Type, Print) Barbara Sperry | | | |
| To Be Completed by Physician/Medical Examiner | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Holly Hill Mem. Garden | | 20c. Location - City or Town, State 12/20/97 Balto. Md. | | 21. Signature of Funeral Service Licensee R. T. Connelly | |
| | 22. Name and Address of Facility Connelly Funeral Home of Essex 300 Mace Ave. Baltimore, Md. 21221 | | 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Metastatic carcinoma Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): | | Approximate Interval Between Onset and Death | | | |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | |
| | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) | | | | | |
| | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| To Be Completed by Physician/Medical Examiner | 28d. Describe how Injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| | 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier M. Miller | | 29c. License number D18598 | | 29d. Date signed (Month, Day, Year) 12/24/97 | |
| To Be Completed by Physician/Medical Examiner | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Miller, M.D. 404 Eastern Blvd (21221) | | 31. Date filed (Month, Day, Year) DEC 23 1997 | | | | | |
| | 32. Registrar's Signature John Davidson-Randall | | 33. State Registrar DEC 23 1997 | | | | | |

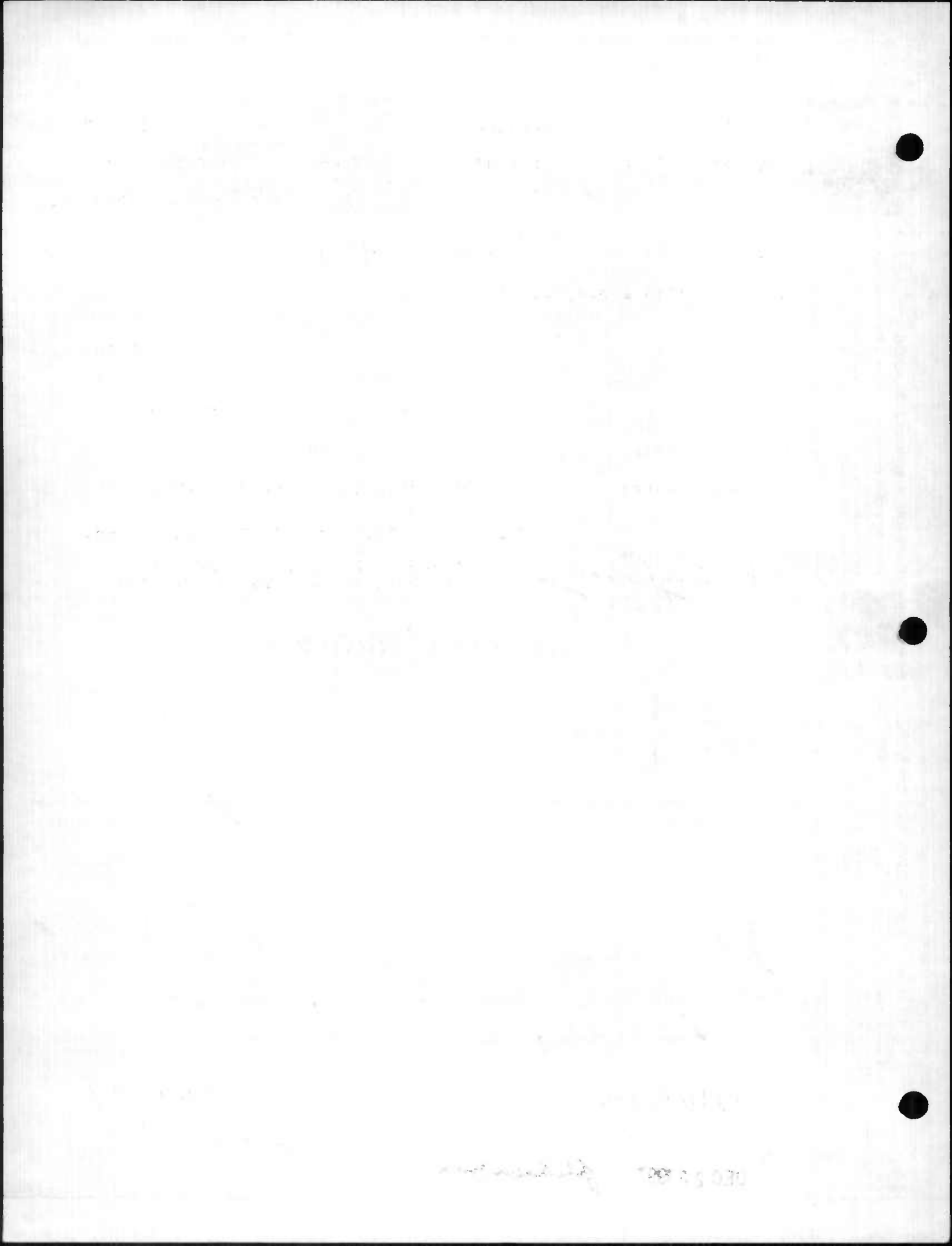
Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38779

| | | | | | | | | |
|---|--|--|---|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Joseph TAGLIAFERRI | | | | 2. Date of Death Month December Day 19 Year 1997 | | 3. Time of Death 7:30 A.M. | |
| | 4a. Facility Name (If not institution, give street and number) Franklin Square Hospital Center | | | | 4b. City, Town, or Location of Death Rosedale | | 4c. County of Death Baltimore | |
| Funeral Director | 5. Social Security Number 219-18-8156 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 71 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) March 13, 1926 | 9. Birthplace (State or Foreign Country) Maryland |
| | Usual Residence of Decedent | | | | | | | |
| To Be Completed by Funeral Director | 10a. State Maryland | 10b. County Baltimore | 10c. City, Town or Location Dundalk | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | 10e. Street and Number 7947 St. Bridget Lane | | | 10f. Zip Code 21222 | | 10g. Citizen of What Country? United States | | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: Korean | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed) 9 Years | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Merchant Marine Electrician | | 16b. Kind of Business/Industry Military | | | |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last) Luigi Tagliaferri | | | | 18. Mother's Name (First, Middle, Maiden Surname) Assunta Fabion | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Wife Mrs. Reatha R. Tagliaferri | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7947 St. Bridget Lane Dundalk, MD 21222 | | | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donellon 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Sacred Ht. of Jesus Cem. | | 20c. Date 12/22/97 | | 20d. Location - City or Town, State Dundalk, Maryland | |
| | 21. Signature of Funeral Service Licensee  | | 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 | | | | | |
| Physician /Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. Bronchopneumonia with abscess formation Due to (or as a consequence of): b. Mesothelioma Due to (or as a consequence of): c. Asbestosis Due to (or as a consequence of): d. Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | Approximate Interval Between Onset and Death 4 days 1 year 10 years |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic obstructive pulmonary disease Congestive heart failure Hypertension | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | 24e. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | 24f. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| State Registrar | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28d. Describe how injury occurred | | | | | |
| | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| State Registrar | 29b. Signature and title of certifier  | | | | 29c. License number D31076 | | 29d. Date signed (Month, Day, Year) 12/22/97 | |
| | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Dr. Orn Eliasson 6830 Hospital Dr. Baltimore, Maryland 21237 | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 23 1997 | | 32. Registrar's Signature  | | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

RICHARD EMERSON TALBERT

2. Date of Death

Month Day Year
DECEMBER 19, 1997

3. Time of Death

9:40 PM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Saint Joseph Medical Center

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

5. Social Security Number

216-46-2052

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

48

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Oct. 21, 1949

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7003 Kenleigh Road

10f. Zip Code

21212

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

N/A

16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Executive

16b. Kind of Business/Industry

Advertising

17. Father's Name (First, Middle, Last)

Berean Earl Talbert

18. Mother's Name (First, Middle, Maiden Surname)

Frances Patricia Keith

19a. Informant's Name/Relationship (Type, Print)

Paula T. Johnson - Sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11 Dulaney Hills Ct., Cockeysville, MD 21030

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Dulaney Valley Mem. Gard. Dec. 22, 1997 Timonium, MD 21093

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Lemmon Funeral Home

10 W. Padonia Rd., Timonium, MD 21093

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

METASTATIC ESOPHAGEAL CARCINOMA

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

28. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D41410

29d. Date signed (Month, Day, Year)

December 19th, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JOGINDER P. MEHTA, M.D. 7620 YORK ROAD TOWSON, MARYLAND 21204

31. Date filed (Month, Day, Year)

DEC 23 1997

32. Registrar's Signature

Julie Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38781

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Doris

THOMAS

2. Date of Death

Month

Day

Year

12 13 97

3. Time of Death

9:55 PM

4a. Facility Name (If not institution, give street and number)

JOHNS HOPKINS BAYVIEW MEDICAL CENTER

4b. City, Town, or Location of Death

BALTO,

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

216-34-3043

6. Sex

1 ☐ M2 ☒ F

7. Age (In yrs. last birthday)

63

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

AUG. 27, 1934

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State
MARYLAND

10b. County

N/A

10c. City, Town or Location

BALTIMORE CITY

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

1401 e. OLIVER ST. apt.406

10f. Zip Code

21213

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: NEGRO

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12TH

N/A

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

ADMINISTRATIVE

16b. Kind of Business/Industry

SOCIAL SECURITY

17. Father's Name (First, Middle, Last)

GROVER MC CREA

18. Mother's Name (First, Middle, Maiden Surname)

IDA RHODES

19a. Informant's Name/Relationship (Type, Print)

VERONICA BROOKS

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1200 N. CENTRAL AVE. BALTO, MD. 21202

20e. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

BALTIMORE NATIONAL DEC. 18TH, 1997 Balto, Md.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Calvin B. Scruggs, Jr.

22. Name and Address of Facility

CALVIN B. SCRUGGS FUNERAL HOME

1412 E. PRESTON STREET BALTO, MD. 21213

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final

disease or condition

resulting in death)

a. Gastrointestinal hemorrhage

Due to (or as a consequence of):

b. Sepsis

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

one day

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dr. R. Sohn MD

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

December 13, 1997.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. R. Sohn JHMC 4940 Easton Ave Balt, MD 21224

31. Date filed (Month, Day, Year)

DEC 23 1997

32. Registrar's Signature

Julia Davidson-Rodale

State
Registrar

Baltimore, Maryland 21215-0020

permitted. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director


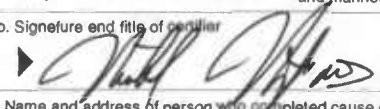
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38782

| | | | | | | | | |
|--|---|---|--|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) LESLIE H. TAYLOR | | | | 2. Date of Death Month December Day 19 Year 1997 | | 3. Time of Death 7:00 AM | |
| | 4a. Facility Name (If not institution, give street and number) 12020 Glen Arm Rd. | | | | 4b. City, Town, or Location of Death Glen Arm | | 4c. County of Death Baltimore | |
| Funeral Director | 5. Social Security Number 365-26-9836 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 71 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) Oct. 15, 1926 | 9. Birthplace (State or Foreign Country) Michigan |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State MD | | 10b. County Baltimore | | 10c. City, Town or Location Glen Arm | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10e. Street and Number 12020 Glen Arm Rd. | | | | 10f. Zip Code 21057 | | 10g. Citizen of What Country? USA | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: WW II | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Machinist | | 16b. Kind of Business/Industry Besser Co. | | |
| 17. Father's Name (First, Middle, Last) Sidney Taylor | | | | 18. Mother's Name (First, Middle, Maiden Surname) Elda Heslip | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Robert M. Taylor | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12020 Glen Arm Rd., Glen Arm, MD 21057 | | | | |
| 20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Memorial Park Cemetery | | Date 12/23/97 | | 20c. Location - City or Town, State Rogers City, MI | | |
| 21. Signature of Funeral Service Licensee  | | | | 22. Name and Address of Facility ALTENBURG FUNERAL HOME, P.A. 6009 Harford Rd., Baltimore, MD 21214 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. immediate Cause (Final disease or condition resulting in death) a. CHRONIC OBSTRUCTIVE LUNG DISEASE Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death 5 YEARS |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CACHEXIA | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury of Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier  | | 29c. License number D 31189 | | 29d. Date signed (Month, Day, Year) 12/19/97 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MICHAEL J. MINKOWSKI, MD, 8813 WARDHAM WOODS RD, BALTIMORE, MD 21234 | | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 23 1997 | | 32. Registrar's Signature  | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permits. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit

8x1

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38783

| | | | | | | | | | |
|---|---|--|--|---|---|---|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Harry Charles Treshman, Jr. | | | | 2. Date of Death Month: December Day: 20, Year: 1997 | | 3. Time of Death 11:15 A.M. | | |
| | 4a. Facility Name (If not institution, give street and number) Manor Care Nursing Home - Rossville | | | | 4b. City, Town, or Location of Death Rosedale | | 4c. County of Death Baltimore County | | |
| Funeral Director | 5. Social Security Number 214-16-6495 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 75 Yrs. | | 8. Date of Birth (Month, Day, Year) Feb. 27, 1922 | | |
| | 9. Birthplace (State or Foreign Country) Maryland | | 10a. State Maryland | | 10b. County Baltimore County | | 10c. City, Town or Location Baltimore | | |
| Usual Residence of Decedent | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number 5127 Terrace Drive | | 10f. Zip Code 21236 | | 10g. Citizen of What Country? U.S.A. | |
| 11. Marital Status <input type="checkbox"/> Navar Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1/2/43-1/4/44 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7th Grade College (1-4or 5+) | |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Clerical | | 16b. Kind of Business/Industry Petroleum Center | | 17. Father's Name (First, Middle, Last) Harry Charles Treshman, Sr. | | 18. Mother's Name (First, Middle, Maiden Surname) Mildred Smith | | 19a. Informant's Name/Relationship (Type, Print) Audrey L. Treshman/Wife | |
| 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5127 Terrace Drive, Baltimore, Maryland 21236 | | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Parkwood Cemetery | | 20c. Location - City or Town, State Baltimore, Maryland | | 20d. Date 12/23/97 | |
| 21. Signature of Funeral Service Licensee Quanta R Thomas | | 22. Name and Address of Facility John C. Miller, Inc. 6415 Belair Road, Baltimore, Maryland 21206 | | 23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Advanced Atherosclerosis Due to (or as a consequence of): Cardiovascular Disease with history of HTN Due to (or as a consequence of): HTN CVA Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | Approximate Interval Between Onset and Death >10 yrs >15 yrs >10 yrs | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| 23c. Were an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 23d. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. HTN Rheumatoid Heart Disease HTN Antisocial Behavior HTN Senile Dementia | | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier Michael A. Hyatt | | 29c. License number 27693 | |
| 29d. Date signed (Month, Day, Year) 12/23/97 | | 30. Name and address of person who completed cause of death (item 23e) (Type, Print) Michael A. Hyatt, 6530 Waltham Ave Baltimore MD 21206 | | 31. Date filed (Month, Day, Year) DEC 23 1997 | | 32. Registrar's Signature Julia Davidson-Randall | | State Registrar | |

Handwritten signature

DEC 3 1931

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38784

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Erma

Faye

UMBARGER

2. Date of Death

Month Day Year
December 18, 1997

3. Time of Death

11:23 P.M.

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Franklin Square Hospital Center

4b. City, Town, or Location of Death

Rosedale

4c. County of Death

Baltimore

5. Social Security Number

230-30-2516

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

69

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)
Oct. 8, 1928

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Dundalk

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

8 Lombardy Drive

10f. Zip Code

21222

10g. Citizen of What Country?

United States

11. Marital Status

☐ Navar Married ☐ Married☐ Widowed ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

☐ Yes ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

G.E.D.

18a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Emmitt Rogers

18. Mother's Name (First, Middle, Maiden Surname)

Mary Baker

19a. Informant's Name/Relationship (Type, Print)

Sandra B. Gutermuth/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8 Lombardy Drive Dundalk, Maryland 21222

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Parkwood Cemetery 12/22/1997

Date

20c. Location - City or Town, State

Parkwood, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Duda-Ruck Funeral Home of Dundalk, Inc.

7922 Wise Ave. Dundalk, Maryland 21222

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Metastatic Lung Cancer

Due to (or as a consequence of):

b. Brain Metastasis

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☒ Yes ☐ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital: ☒ Inpatient☐ ER/Outpatient☐ DOAOther: ☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Accident☐ Suicide☐ Homicide☐ Pending investigation☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

RD 2323

29d. Date signed (Month, Day, Year)

12/18/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Kristin Pena 9000 Franklin Square Drive Baltimore Maryland 21237

31. Date filed (Month, Day, Year)

DEC 23 1997

State
Registrar

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 38785

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

CHARLES D. UHLER

2. Date of Death

Dec. 20, 1997

3. Time of Death

6:15 P.M.

4a. Facility Name (If not institution, give street and number)

3110 Old Westminster Road

4b. City, Town, or Location of Death

Finksburg

4c. County of Death

Carroll Co.

5. Social Security Number

213-32-5588

6. Sex

☒ M ☐ F

7. Age (in yrs. last birthday)

61

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

July 25, 1936

9. Birthplace (State or Foreign Country)

Balto. Co. Md.

Usual Residence of Decedent

10a. State

Md.

10b. County

Carroll

10c. City, Town or Location

Finksburg

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

3110 Old Westminster Road

10f. Zip Code

21048

10g. Citizen of What Country?

USA

11. Marital Status

☐ Navar Married ☒ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☒ Yes ☐ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

10 Grade

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Balto. Co. Parks & Rec.

16b. Kind of Business/Industry

Maintenance

17. Father's Name (First, Middle, Last)

Denton G. Uhler

18. Mother's Name (First, Middle, Maiden Surname)

Hilda Roper

19a. Informant's Name/Relationship (Type, Print)

Mrs. Laura M. Uhler (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3110 Old Westminster Road Finksburg, Md. 21048

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Carroll Cremation Service 12/22/97 Hampstead, Md.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

11824 Reisterstown Road

ELINE FUNERAL HOME Reisterstown, Md. 21136

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ESOPHAGEAL CANCER

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

6 Mo.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner? (Check only one)

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient☐ ER/Outpatient☐ DOA

Other:

☐ Nursing Home☒ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation
☐ Accident ☐ Could not be determined
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Norman G. Galtman

29c. License number

D26385

29d. Date signed (Month, Day, Year)

12-22-97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Norman G. Galtman, 218 Washington Heights Medical Bldg Westminister Md

31. Date filed (Month, Day, Year)

DEC 23 1997

32. Registrar's Signature

Julia Davidson-Rodriguez

State
RegistrarBaltimore, Maryland 21215-0020
Permit: Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural," or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

[Faint, illegible text covering the majority of the page, likely bleed-through from the reverse side.]

[Handwritten signature or initials.]

DEC 1 1983

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38786

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

John N. Vasilarakis

2. Date of Death

Month Day Year
December 20, 1997

3. Time of Death

2:05 A.M.

4a. Facility Name (If not institution, give street and number)

900 S. Ponca Street

4b. City, Town, or Location of Death

Baltimore City

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

216-62-6707

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

74

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Dec. 7, 1923

9. Birthplace (State or Foreign Country)

Greece

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

900 S. Ponca Street

10f. Zip Code

21224

10g. Citizen of What Country?

Greece

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12) College (1-4 or 5+)
6th

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Cook

16b. Kind of Business/Industry

Restaurant

17. Father's Name (First, Middle, Last)

Nicholas Vasilarakis

18. Mother's Name (First, Middle, Maiden Surname)

Anna Mastromanolis

19a. Informant's Name/Relationship (Type, Print)

Sofia Vasilarakis, wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

900 S. Ponca Street, Baltimore, Md. 21224

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Oak Lawn Cemetery

Date

12-22-97

20c. Location - City or Town, State

Baltimore, Md.

21. Signature of Funeral Service Licensee

Ann S. Hutchins

22. Name and Address of Facility

Bradley-Ashton-Dabrowski-Matthews Funeral Home, Inc.
2134 Willow Spring Rd., Baltimore, Md. 21222

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. *Constrictive heart failure*

Due to (or as a consequence of):

2 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. *Coronary artery disease*

Due to (or as a consequence of):

20 years

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

Other:

4 ☐ Nursing Home

5 ☒ Residence

6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Nicholas J. Fortuin MD

29c. License number

DD1666

29d. Date signed (Month, Day, Year)

12-22-97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Nicholas J. Fortuin MD

10755 FALLS RD

Lutherville and 21093

31. Date filed (Month, Day, Year)

DEC 23 1997

32. Registrar's Signature

Julia Davidson-Randall

State Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

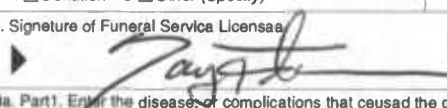
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Amended #7,8,19b per FH G755 1/7/98 EW

97 38787

| | | | | | |
|--|---|--|--|--------------------------------|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) SARA R VERSCHLEISSER | | 2. Date of Death Month DEC. Day 18 Year 1997 | | 3. Time of Death 11:30 AM |
| | 4a. Facility Name (If not institution, give street and number) 3200 W. STRATHMORE AVE. | | 4b. City, Town, or Location of Death BALTIMORE | | 4c. County of Death N/A |
| Funeral Director | 5. Social Security Number 064-18-6782 | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 75 74 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. |
| | 8. Date of Birth (Month, Day, Year) OCT. 17, 1923 | | 9. Birthplace (State or Foreign Country) NEW YORK | | |
| To Be Completed by Funeral Director | Usual Residence of Decedent | | | | |
| | 10a. State MD | 10b. County N/A | 10c. City, Town or Location BALTIMORE | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| | 10e. Street and Number 3200 W. STRATHMORE AVE. | | 10f. Zip Code 21215 | | 10g. Citizen of What Country? USA |
| | 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
| | 14. Race - American Indian, Black, White, etc. Specify: WHITE | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5+ | | |
| | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) TEACHER | | 16b. Kind of Business/Industry EDUCATION | | |
| | 17. Father's Name (First, Middle, Last) MOSHE LEIB HAHN | | 18. Mother's Name (First, Middle, Maiden Surname) TOBY WEINBERG | | |
| | 19a. Informant's Name/Relationship (Type, Print) SAMUEL VERSCHLEISSER (HUS.) | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3200 W. STRATHMORE AVE. BALTO., MD 21215 3200 W. Strathmore Ave Balto., MD 21215 | | |
| | 20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) BETH DAVID (ANSHE SFARD CONG.) | | 20c. Location - City or Town, State 12/17/97 ELMONT, LI, NY |
| | 21. Signature of Funeral Service Licensee  | | 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN RD., PIKESVILLE, MD 21208 | | |
| 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Metastatic Breast Cancer Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | |
| 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | |
| 24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide | | | | | |
| 28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 28d. Describe how injury occurred 28e. Place of Injury: At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | |
| 29b. Signature and title of certifier  29c. License number MD 518320 29d. Date signed (Month, Day, Year) 12/19/97 | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) John P. G. M.D. Johns Hopkins Oncology Ctr Baltimore MD 21287 | | | | | |
| 31. Date filed (Month, Day, Year) DEC 23 1997 | | | | | |
| 32. Registrar's Signature  | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

1911

1911

1911

1911

1911

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38788

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Fred Dodd Wilson, Jr.

2. Date of Death

Month Day Year
DEC 22, 1997

3. Time of Death

7:50 AM

4a. Facility Name (If not institution, give street and number)

8518 Winddance Way

4b. City, Town, or Location of Death

Columbia

4c. County of Death

Howard

Funeral
Director

5. Social Security Number

168-16-8993

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

76 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
June 26, 1921

9. Birthplace (State or Foreign Country)

New Jersey

Usual Residence of Decedent

10e. State

MD

10b. County

Howard

10c. City, Town or Location

Columbia

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8518 Winddance Way

10f. Zip Code

21045

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: 1942 - 45

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Manufacturers Rep.

16b. Kind of Business/Industry

Sales

17. Father's Name (First, Middle, Last)

Fred D. Wilson, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Dorothy Tanner

19a. Informant's Name/Relationship (Type, Print)

Shirley E. Wilson/wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8800 Walther Blvd. Apt. 2316 Parkville, MD 21234

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Crematory, Inc. 12/23/97

Date

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

Edward A. Gregorchik

22. Name and Address of Facility

Cremation Society of Maryland, Inc.
299 Frederick Rd. Baltimore, MD 21228

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e.

Dementia

Due to (or as a consequence of):

b.

Parkinson's Disease

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

Yrs

Yrs

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

29b. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
29c. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

H.A. Oke

29c. License number

D31172

29d. Date signed (Month, Day, Year)

Dec 22 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

H.A. Oke MD 3460 Bluffton Court An 103 EC MD 21043

State
Registrar

31. Date filed (Month, Day, Year)

DEC 23 1997

32. Registrar's Signature

John Davidson-Randall

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be completed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 38789

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|---|---|--|--|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Sally Ann Wessner | | | | 2. Date of Death Month Day Year DEC 20, 1997 | | 3. Time of Death 8:15 PM | |
| | 4a. Facility Name (If not institution, give street and number) Greater Baltimore Medical Center | | | | 4b. City, Town, or Location of Death Towson | | 4c. County of Death Baltimore | |
| Funeral Director | 5. Social Security Number 267-52-0723 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 58 Yrs. | | 8. Date of Birth (Month, Day, Year) JAN 29, 1939 | |
| | 9. Birthplace (State or Foreign Country) West Virginia | | 10a. State MD | | 10b. County Baltimore | | 10c. City, Town or Location Towson | |
| 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 10e. Street and Number 822 East Joppa Road | | 10f. Zip Code 21286 | | 10g. Citizen of What Country? USA | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5+ | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Librarian | | 16b. Kind of Business/Industry City Schools | | | | |
| 17. Father's Name (First, Middle, Last) Franklin Matthews | | | | 18. Mother's Name (First, Middle, Maiden Surname) Lena Norris | | | | |
| 19a. Informant's Name/Relationship (Type, Print) John M. Wessner/Husband | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 822 E. Joppa Road Towson, MD 21286 | | | | |
| 20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory, Inc. | | 20c. Date 12/23/97 | | 20d. Location - City or Town, State Baltimore, MD | | |
| 21. Signature of Funeral Service Licentiate Edward A. Gregorchik | | | | 22. Name and Address of Facility Cremation Society of MD, Inc. 299 Frederick Rd. Baltimore, MD 21228 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Stroke INTRACEREBRAL BLEED | | | | | | | | |
| 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | |
| 23c. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| 29b. Signature and title of certifier [Signature] | | | | 29c. License number D50791 | | 29d. Date signed (Month, Day, Year) 12/23/97 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6569 N. CHARLES ST #411 BALT, MD 21204 | | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 23 1997 | | 32. Registrar's Signature [Signature] | | | | | | |

Baltimore, Maryland 21215-0020

permitted. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the final transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



[Faint, illegible handwritten text]

DEC 8 1961

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38790

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

EARL J. WILLIAMS

2. Date of Death

December 21 1997

3. Time of Death

12:10 PM

4a. Facility Name (If not institution, give street and number)

BALTIMORE VA MEDICAL CENTER

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

220-22-9537

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

68 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

4-18-1929

9. Birthplace (State or Foreign Country)

Md

Usual Residence of Decedent

10a. State

Md

10b. County

Baltimore

10c. City, Town or Location

Randallstown

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3926 Noye Circle

10f. Zip Code

21133

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: 2-16-53
2-17-55

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

10th grade

College (14 or 16+)

N/A

16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Heavy Equipment Operator

16b. Kind of Business/Industry

General Electric

17. Father's Name (First, Middle, Last)

Earl Williams

18. Mother's Name (First, Middle, Maiden Surname)

Bertha Carter

19a. Informant's Name/Relationship (Type, Print)

Ethel Williams / wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3926 Noye Circle Apt. 101 Randallstown, Md 21133

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Garrison Forest Vet

Date

12-26-97 Owings Mills, Md

21. Signature of Funeral Service Licensee

Gabrielle Cook

22. Name and Address of Facility

William C. Marsh F/A - West
4300 Wabash Ave Baltimore, Md 21215

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e.

Due to (or as a consequence of):

Pneumonia

Approximate Interval Between Onset and Death

6 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24e. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

NEERAT CHOPRA

29c. License number

P10230

29d. Date signed (Month, Day, Year)

December 21, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

NEERAT CHOPRA

10 N. GILBENE ST, BALTIMORE, MD 21201

31. Date filed (Month, Day, Year)

DEC 23 1997

32. Registrar's Signature

John T. ...

State
Registrar

Baltimore, Maryland 21215-0020

Permit, Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

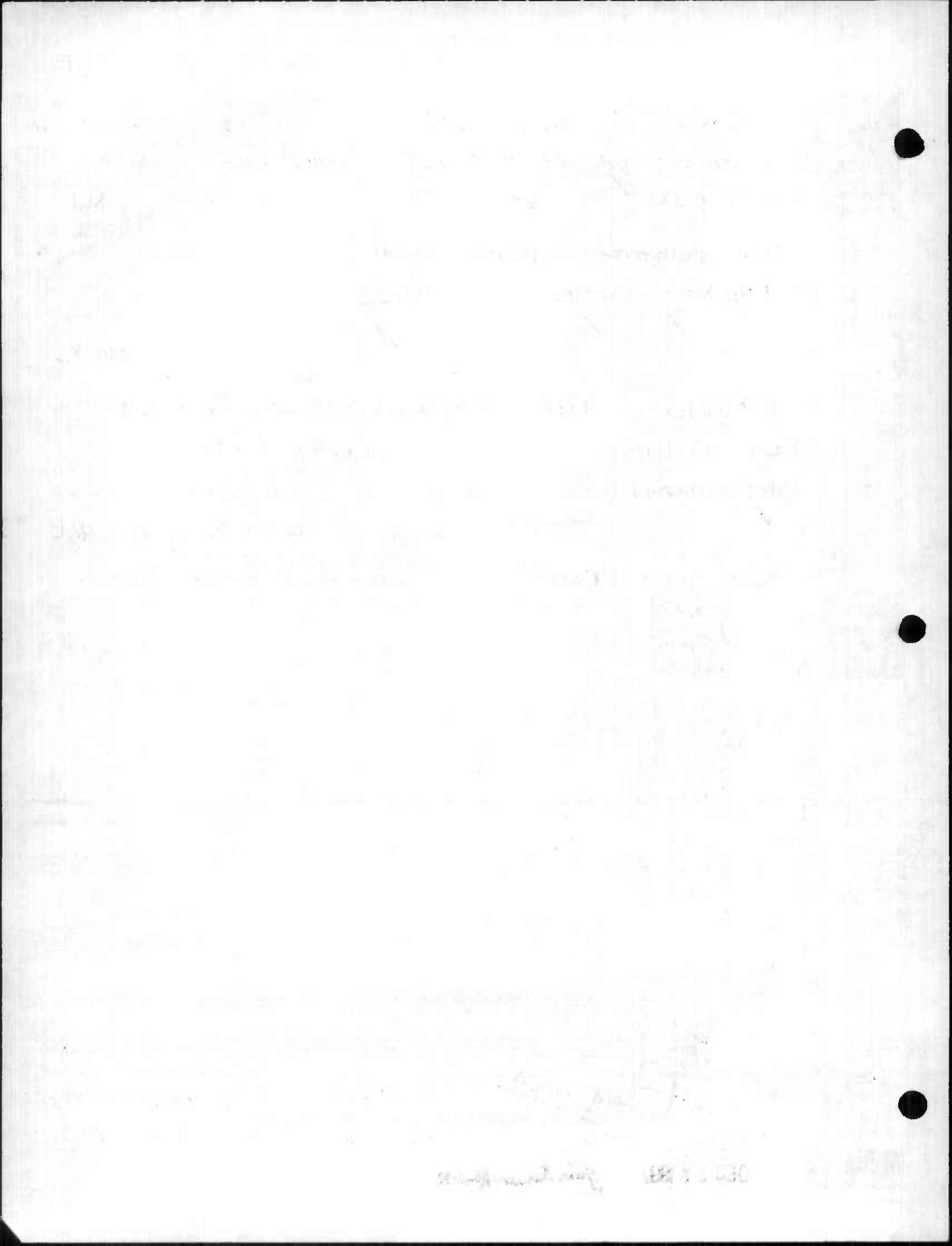
Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



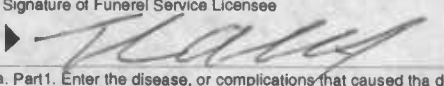
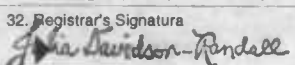
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38791

| | | | | | | | | |
|--|---|---|---|--|--|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) LILLIAN WOLF | | | | 2. Date of Death Month DEC Day 19 Year 1997 | | 3. Time of Death 100 PM | |
| | 4a. Facility Name (If not institution, give street and number) MERCY HOSPITAL | | | | 4b. City, Town, or Location of Death BALTIMORE | | 4c. County of Death N/A | |
| Funeral Director | 5. Social Security Number 220-05-5111 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 77 Yrs. | | 8. Date of Birth (Month, Day, Year) March 15, 1920 | |
| | 9. Birthplace (State or Foreign Country) Maryland | | 10a. State Maryland | | 10b. County Baltimore | | 10c. City, Town or Location Owings Mills | |
| To Be Completed by Funeral Director | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number 6 Trolod Court | | 10f. Zip Code 21117 | | 10g. Citizen of What Country? U. S. A. | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6th Grade College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker | | 16b. Kind of Business/Industry Own Home | | | |
| | 17. Father's Name (First, Middle, Last) George Bowers | | | | 18. Mother's Name (First, Middle, Maiden Surname) Marian Bell | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Wallace Wolf (Son) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2581 Mindi Drive, Manchester, Maryland 21102 | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Garrison Forest Md. Vets. | | 20c. Location - City or Town, State 12/23/97 Owings Mills, Maryland | | | |
| | 21. Signature of Funeral Service Licensee  | | | | 22. Name and Address of Facility Schimunek Funeral Home Inc. 3331 Brehms Lane, Baltimore, Maryland 21213 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| | 23b. Approximate interval between Onset and Death 8 hours | | | | | | | |
| | Physician /Medical Examiner | 23a. Immediate Cause (Final disease or condition resulting in death) a. Stroke Due to (or as a consequence of): b. peripheral vascular disease Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | | | | | |
| 23a. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. abdominal aortic aneurysm | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | | | | | | |
| 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 28d. Describe how injury occurred 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| 29b. Signature and title of certifier Joseph Costa, MD | | | | | | | | |
| 29c. License number D42634 | | | | | | | | |
| 29d. Date signed (Month, Day, Year) DEC 19, 1997 | | | | | | | | |
| State Registrar | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOSEPH COSTA, MD 301 ST PAUL PLACE BALTIMORE, MD 21202 | | | | | | | |
| | 31. Date filed (Month, Day, Year) DEC 23 1997 | | | | 32. Registrar's Signature  | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

18

1881

1881

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38792

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Henderson S. Willing

2. Date of Death

Month Day Year
December 21, 1997

3. Time of Death

8:45 AM

4a. Facility Name (If not institution, give street and number)

613 Middlesex Road

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Baltimore

5. Social Security Number

219-09-5461

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

83

8. Date of Birth

Month Day Year

May 31, 1914

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

613 Middlesex Road

10f. Zip Code

21221

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12th grade

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Tavern Owner

16b. Kind of Business/Industry

Tavern

17. Father's Name (First, Middle, Last)

Alonzo Willing

18. Mother's Name (First, Middle, Maiden Surname)

Lilly Henderson

19a. Informant's Name/Relationship (Type, Print)

Barbara Amos (wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

613 Middlesex Road, Baltimore, MD 21221

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Gardens of Faith Cem.

Date

12/23/97 Baltimore, Maryland

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Schimunek Funeral Homes, Inc.
9705 Belair Rd., Baltimore, MD 21236

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. PANCREATIC CANCER

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

6 MONTHS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, term, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

D.O.

29c. License number

H35593

29d. Date signed (Month, Day, Year)

DEC. 22, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. JOHN J. LOH 1124 MACE AVE., BALTIMORE, MD. 21221

31. Date filed (Month, Day, Year)

DEC 23 1997

32. Registrar's Signature

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

1041

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38793

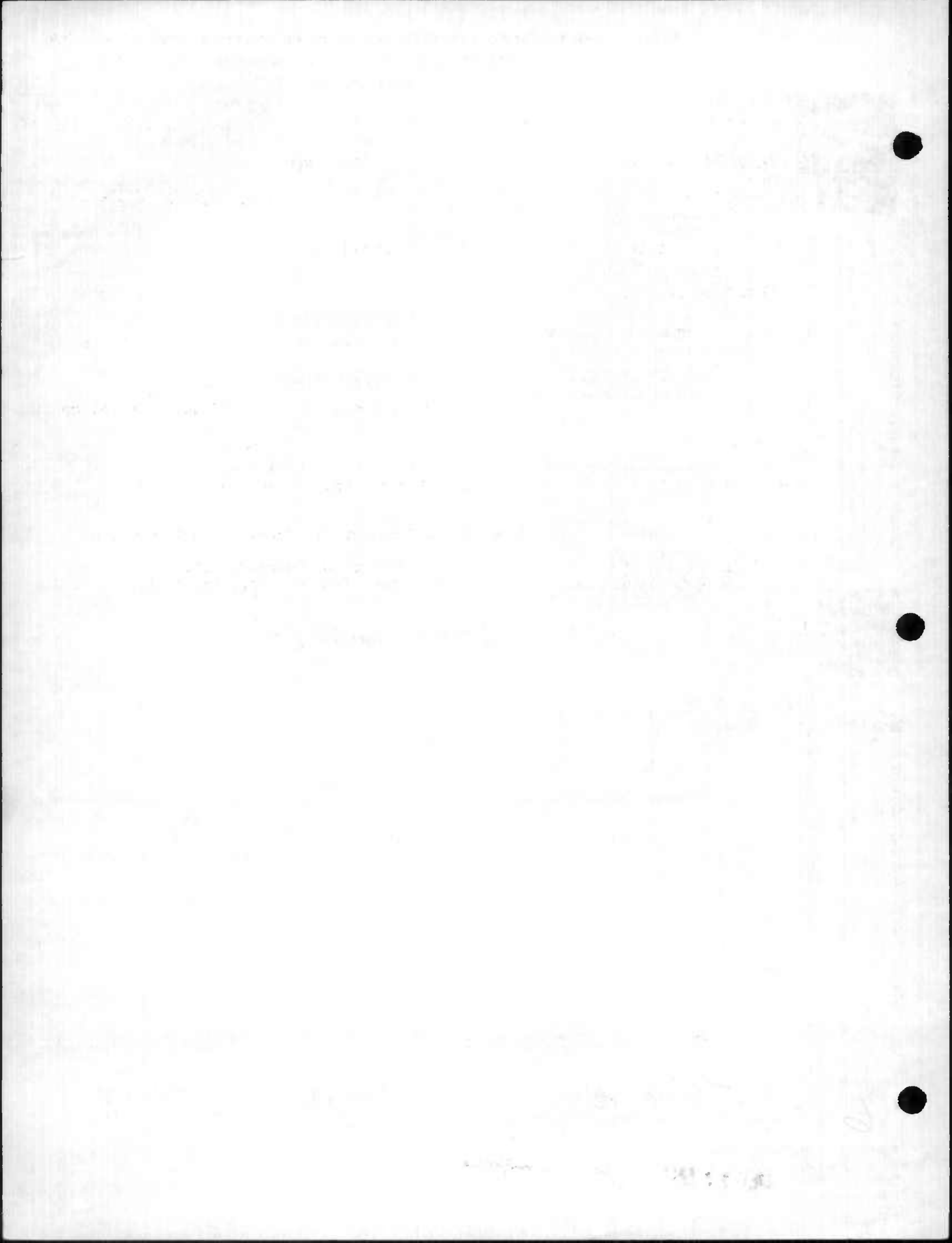
| | | | | | | | | | |
|---|---|--|--|---|--|--|---|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Joseph Harper Wessell | | | | 2. Date of Death Month December Day 20 , Year 1997 | | 3. Time of Death 2:11 PM | | |
| | 4a. Facility Name (If not institution, give street and number) 127 McGlothlin Rd., | | | | 4b. City, Town, or Location of Death Conowingo | | 4c. County of Death Cecil | | |
| Funeral Director | 5. Social Security Number 217 52 0742 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 49 Yrs. | | 8. Date of Birth (Month, Day, Year) Sept. 15, 1948 | | |
| | 9. Birthplace (State or Foreign Country) Maryland | | 10a. State Maryland | | 10b. County Cecil | | 10c. City, Town or Location Conowingo | | |
| To Be Completed by Funeral Director | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 10e. Street and Number 127 McGlothlin Rd. | | 10f. Zip Code 21918 | | |
| | 10g. Citizen of What Country? United States | | | | 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | |
| | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: White | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | |
| | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Utility Serviceman | | | | 16b. Kind of Business/Industry Oil Co. Heating and Airconditn | | | | |
| | 17. Father's Name (First, Middle, Last) William Wessell | | | | 18. Mother's Name (First, Middle, Maiden Summa) (Unknown) | | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Beverly Wessell / Wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 127 McGlothlin Rd., Conowingo MD 21918 | | | | |
| | 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Green Mount Crematory | | 20c. Location - City or Town, State 12/22/97 Baltimore, MD | | |
| | 21. Signature of Funeral Service Licensee <i>Stephen D. Lohrmann</i> | | | | 22. Name and Address of Facility CAFA Stephen D. Lohrmann P.A. 8717 Green Pastures Dr., Baltimore, MD 21286 | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Myocardial Infarction | | | | Approximate Interval Between Onset and Death | | | | |
| | 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 23c. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 28d. Describe how injury occurred | | | | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | 29b. Signature and title of certifier <i>T. Biondo MD</i> | | 29c. License number D42800 | | 29d. Date signed (Month, Day, Year) 12/22/97 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) T. Biondo 319 S. Union Ave, Hdg, MD 21078 | | | | 31. Date filed (Month, Day, Year) DEC 23 1997 | | | | 32. Registrar's Signature <i>Julia Davidson-Henderson</i> | |

Baltimore, Maryland 21215-0020

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21268-0760

State Registrar



97-7048-005

B.K.S

DAVID LEON WICKLINE

Items: 23aPart Ia, 27, 28a-f Per Film G-754 12-31-97RC

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38794

Physician
/Medical
Examiner

DAVID LEON WICKLINE

2. Date of Death
Month Day Year
DEC. 6, 1997
3. Time of Death
10:45 AMFuneral
Director

4a. Facility Name (If not institution, give street and number)

SAINT JOSEPH'S HOSPITAL

4b. City, Town, or Location of Death

TOWSON

4c. County of Death

BALTIMORE

5. Social Security Number

234-13-5003

6. Sex

M ☒ F ☐

7. Age (In yrs. last birthday)

33

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year
July 22, 1964

9. Birthplace (State or Foreign Country)

Indiana

Usual Residence of Decedent

10a. State

VA

10b. County

Carroll

10c. City, Town or Location

Hillsville

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

119 Jett St.

10f. Zip Code

24343

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

10

College (14 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Boiler Operator

16b. Kind of Business/Industry

Furniture Co.

17. Father's Name (First, Middle, Last)

Clarence E. Wickline, Jr.

18. Mother's Name (First, Middle, Maiden Surname)

Virginia Gean Masters

19a. Informant's Name/Relationship (Type, Print)

Clarence E. Wickline, Jr.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Rt. 1 Box 364, Peterstown, WV 24963

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☒ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Clemons Cemetery

Date

12/10/97

20c. Location - City or Town, State

Mercer County, WV

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

ALTENBURG FUNERAL HOME, P.A.

6009 Harford Rd., Baltimore, MD 21214

23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line.

Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a. ACUTE COCAINE AND NARCOTIC INTOXICATION

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☒ Yes 2 ☐ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☒ Yes 2 ☐ No25. Was case referred to medical
examiner?☒ Yes ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☒ Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☒ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

Found 12-6-97

28b. Time of

Injury

Found 10:15a

28c. Injury at

Work?

☒ Yes ☐ No

28d. Describe how injury occurred

Unknown

28e. Place of Injury - At home, farm, street, factory, office

building, etc. (Specify)

Found In Parking Lot

28f. Location (Street and Number or Rural Route Number,

City or Town, State)

St. Joseph's Hospital, Balt. Co., Md.

29a. Certifier
(Check only
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dennis J. Chute MD

29c. License number

O.C.M.E

29d. Date signed (Month, Day, Year)

DEC. 7, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dennis J. Chute MD

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

DEC 23 1997

32. Registrar's Signature

Julia Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

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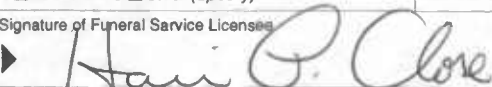
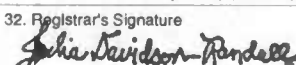
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38795

| | | | | | | | |
|---|--|--|---|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) FANNIE WILLIAMS | | | 2. Date of Death Month DECEMBER Day 19 Year 1997 | | 3. Time of Death 12:13 PM | |
| | 4a. Facility Name (If not institution, give street and number) NORTHWEST HOSPITAL CENTER | | | 4b. City, Town, or Location of Death RANDALLSTOWN | | 4c. County of Death BALTIMORE | |
| Funeral Director | 5. Social Security Number 216-36-6533 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 59 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) 12 30 1937 |
| | 9. Birthplace (State or Foreign Country) Maryland | | | | | | |
| To Be Completed by Funeral Director | 10a. State Maryland | | 10b. County Baltimore Co. | | 10c. City, Town or Location Pikesville | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |
| | 10e. Street and Number 3 Arrow Head Court | | | 10f. Zip Code 21208 | | 10g. Citizen of What Country? U.S.A. | |
| | 11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Black |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Nursing | | 16b. Kind of Business/Industry Private Duty | | |
| | 17. Father's Name (First, Middle, Last) Evans Williams | | | 18. Mother's Name (First, Middle, Maiden Sumama) Sally Williams | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Sarah R. Taylor/Sister | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3 Arrow Head Court, Pikesville, Maryland 21208 | | | |
| | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Arbutus Memorial Prk | | Date 12/24 | | 20c. Location - City or Town, State Catonsville, Md. |
| | 21. Signature of Funeral Service Licensee  | | 22. Name and Address of Facility William C. Brown Community Funeral Home 1206 W. North Avenue, Baltimore, Md. 21217 | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. a. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE Due to (or as a consequence of): b. END - STAGE RENAL DISEASE Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | | | | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | |
| Physician /Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | |
| | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | |
| | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | |
| | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28d. Describe how injury occurred | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier  MD | | | | | |
| | | 29c. License number D43481 | | 29d. Date signed (Month, Day, Year) DECEMBER 19, 1997 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MICHAEL ROTHKIN NORTHWEST HOSPITAL 5401 Old Court Road RANDALLSTOWN MARYLAND 21133 | | | | | | | |
| State Registrar | 31. Date filed (Month, Day, Year) DEC 23 1997 | | | 32. Registrar's Signature  | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

87 38796

| | | | | | | | | |
|--|--|---|--|---|--|--|--|---|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Charles YARASHEVICH | | | | 2. Date of Death Month December Day 18 , Year 1997 | | 3. Time of Death 8:00 am | |
| | 4a. Facility Name (If not institution, give street and number) Franklin Square Hospital Center | | | | 4b. City, Town, or Location of Death Rosedale | | 4c. County of Death Baltimore | |
| Funeral Director | 5. Social Security Number 219-01-1436 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 80 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) July 15, 1917 | 9. Birthplace (State or Foreign Country) OHIO |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State Md. | | 10b. County Baltimore | | 10c. City, Town or Location Essex | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10e. Street and Number 72 Berkshire Road | | | | 10f. Zip Code 21221 | | 10g. Citizen of What Country? USA | | |
| 11. Marital Status <input type="checkbox"/> Navar Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever In U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 3 yrs College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Steel Worker | | | 16b. Kind of Business/Industry Beth Steel | |
| 17. Father's Name (First, Middle, Last) Adam Yarashevich | | | | 18. Mother's Name (First, Middle, Maiden Surname) unknown | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Robert Jenkins/step-son | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 72 Berkshire Road Baltimore Md. 21221 | | | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory Inc. | | Date 12/19/97 | | 20c. Location - City or Town, State Baltimore Md. |
| 21. Signature of Funeral Service Licensee R. Terry Connelly | | | | 22. Name and Address of Facility Connelly Funeral Home of Essex 300 Mace Ave. Baltimore Md. 21221 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. Congestive Heart Failure Due to (or as a consequence of): b. Atrial Fibrillation Due to (or as a consequence of): c. Pneumonia Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death 2 days 4 days 4 days |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Alzheimers Disease Parkinsons Disease | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide | | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. Describe how injury occurred | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. Signature and title of certifier Michael F. Picerno | | 29c. License number D0051356 | | 29d. Date signed (Month, Day, Year) 12/18/97 |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) 9000 Franklin Square Dr Rosedale MD, Michael F Picerno | | | | 31. Date filed (Month, Day, Year) DEC 29 1997 | | | | |

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

CONFIDENTIAL

DEC 8 1963

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38797

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Claudette Zimmerman

2. Date of Death

Month

Day

Year

3. Time of Death

1558

4a. Facility Name (If not institution, give street and number)

University of Maryland Medical System

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Baltimore

5. Social Security Number

213-32-7649

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

62 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

1-2-1935

9. Birthplace (State or Foreign Country)

IL

Usual Residence of Decedent

10a. State

MD

10b. County

NA

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2702 Keyworth Avenue

10f. Zip Code

21215

10g. Citizen of What Country?

U.S.A

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th grade

College (1-4 or 5+)

NA

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Counselor

16b. Kind of Business/Industry

Woodbourne Juvenile

17. Father's Name (First, Middle, Last)

Emmett Benjamin

18. Mother's Name (First, Middle, Maiden Surname)

Dorothy Marshall

19a. Informant's Name/Relationship (Type, Print)

James Armstead - Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

921 N. Carrollton Avenue Balto, MD 21217

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Arbutus Memorial Park

Date

12-22-97 Arbutus, MD

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Michael W. Ware

22. Name and Address of Facility

March F.H. West 21215
4300 Wabash Avenue Balto, MD

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e.

Coronary Artery Disease

Due to (or as a consequence of):

b.

Pulmonary Hypertension

Due to (or as a consequence of):

c.

Renal Failure

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

J. Thomas Dooley, MD

29c. License number

5509

29d. Date signed (Month, Day, Year)

12/16/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

J. Thomas Dooley 42 S. Greene St. Baltimore, MD

31. Date filed (Month, Day, Year)

DEC 23 1997

32. Registrar's Signature

J. Thomas Dooley

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38798

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | | | | |
|--|--|---|--|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last) Cecilia Zeller | | | | 2. Date of Death Month 12 Day 19 Year 97 | | 3. Time of Death 7:10 pm | |
| 4a. Facility Name (If not institution, give street and number) Johns Hopkins Genatnrs Center | | | | 4b. City, Town, or Location of Death Baltimore | | 4c. County of Death N/A | |
| 5. Social Security Number 214-16-5564 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 90 Yrs. | | 8. Date of Birth (Month, Day, Year) 10-25-07 | |
| 9. Birthplace (State or Foreign Country) MARYLAND | | | | | | | |
| 10a. State MD. | | 10b. County N/A | | 10c. City, Town or Location Baltimore | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10e. Street and Number 2700 Fait Ave | | | | 10f. Zip Code 21224 | | 10g. Citizen of What Country? USA | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 YRS College (1-4 or 5+) _____ | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Seamstress | | 16b. Kind of Business/Industry Misty Harbor | |
| 17. Father's Name (First, Middle, Last) JOHN Majchazak | | | | 18. Mother's Name (First, Middle, Maiden Surname) Catherine Wietrzykowska | | | |
| 19a. Informant's Name/Relationship (Type, Print) Miss Helen Majchazak | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State/Zip Code) 2700 Fait Ave Balto MD 21224 | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) St Stanislaus Cem | | 20c. Date 12-23 | | 20d. Location - City or Town, State Balto MD | |
| 21. Signature of Funeral Service Licensee Charles R. Kozzowski | | | | 22. Name and Address of Facility Kozzowski F.H. 3505 Fleet St Balto 21224 | | | |
| Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| Immediate Cause (Final disease or condition resulting in death) | | e. Aspiration Pneumonia | | | | Approximate Interval Between Onset and Death 1 week | |
| | | Due to (or as a consequence of): | | | | | |
| | | b. Cerebral Vascular Accident | | | | 9 months | |
| | | Due to (or as a consequence of): | | | | | |
| | | c. _____ | | | | | |
| | | Due to (or as a consequence of): | | | | | |
| | | d. _____ | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| Hypertension | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | |
| Dementia | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | | 28d. Describe how injury occurred | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier Colleen Christmas | | 29c. License number D51185 | | 29d. Date signed (Month, Day, Year) 12/20/97 | |
| 30. Name and address of person who completed cause of death (item 23e) (Type, Print) Colleen Christmas MD 5505 Hopkins Bayview Circle, Baltimore, MD 21224 | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 23 1997 | | 32. Registrar's Signature John Davidson-Randall | | | | | |

State Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38799

| | | | | | | | | | | | |
|--|---|---|--|--|--|---|---|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Rosario Arcidiacono | | | | | | 2. Date of Death Month Day Year December 6, 1997 | | 3. Time of Death 1:37 AM | | |
| | 4a. Facility Name (If not institution, give street and number) 18204 Rolling Meadow Way | | | | | | 4b. City, Town, or Location of Death Olney | | 4c. County of Death Montgomery | | |
| Funeral Director | 5. Social Security Number 577-20-6225 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 84 Yrs. | | 8. Date of Birth (Month, Day, Year) Feb. 24, 1913 | | 9. Birthplace (State or Foreign Country) Massachusetts | | |
| | Usual Residence of Decedent | | | | | | | | | | |
| 10a. State MD | | 10b. County Montgomery | | 10c. City, Town or Location Olney | | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| 10e. Street and Number 18204 Rolling Meadow Way | | | | 10f. Zip Code 20832 | | | 10g. Citizen of What Country? USA | | | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Barber | | | 16b. Kind of Business/Industry Hair | | | | |
| 17. Father's Name (First, Middle, Last) Peter Arcidiacono | | | | | | 18. Mother's Name (First, Middle, Maiden Surname) Vita Leonardi | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Nunziatina Arcidiacono (wife) | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18204 Rolling Meadow Way, Olney, MD 20832 | | | | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) Entombment | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Gate of Heaven Cemetery | | Date 12/9/97 | | 20c. Location - City or Town, State Silver Spring, MD | | | |
| 21. Signature of Funeral Service Licensee  | | | | 22. Name and Address of Facility Francis J. Collins Funeral Home, Inc. 500 University Blvd. West Silver Spring, MD 20901 | | | | | | | |
| 23a. Pert I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. Arteriosclerotic Cardiovascular Disease Due to (or as a consequence of): Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | | | | | | | | | Approximate Interval Between Onset and Death years | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. Signature and title of certifier  | | | | 29c. License number 208381 | | 29d. Date signed (Month, Day, Year) December 8, 1997 | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Benjamin Avrunin, 18111 Prince Philip Drive, Olney, MD 20832 | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 09 1997 | | | | 32. Registrar's Signature  | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

87 38800

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

E. Doreen Armstrong-Wilson

2. Date of Death

Nov. 30, 1997

3. Time of Death

8:55am

4a. Facility Name (If not institution, give street and number)

Holy Cross Hospital

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

064-34-0602

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

78

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Oct. 28, 1919

9. Birthplace (State or Foreign Country)

Parika, Guyana

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

5024 Adrian Street

10f. Zip Code

20850

10g. Citizen of What Country?

Guyana

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: Black

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Nurse

16b. Kind of Business/Industry

Health Care

17. Father's Name (First, Middle, Last)

Edward Armstrong

18. Mother's Name (First, Middle, Maiden Surname)

Dulcina Ross

19a. Informant's Name/Relationship (Type, Print)

Samantha Wilson-Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2010 Rockland Ave Rockville, MD 20851

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☒ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Volusia Memorial Cem. 12/3/97

Date

20c. Location - City or Town, State

Ormond Bch., FL

21. Signature of Funeral Service Licensee

Daniel Simons

22. Name and Address of Facility

Edward Sagel Funeral Direction

1091 Rockville Pike Rockville MD 20852

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final
disease or condition
resulting in death)

a. Atherosclerotic Coronary Disease

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ NoHospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation
6 ☐ Could not be determined28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury28c. Injury at
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D09834

29d. Date signed (Month, Day, Year)

Dec. 1, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. B. Rosenbaum 3720 Farragut Ave. Kensington, MD

31. Date filed (Month, Day, Year)

DEC 11 1997

32. Registrar's Signature

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural," or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
202-358-2020.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38801

| | | | | | | | | |
|---|---|--|---|--------------------------------------|--|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Martha Callahan Atkinson | | | | 2. Date of Death Month Day Year December 8, 1997 | | 3. Time of Death 3:55 A.M. | |
| | 4a. Facility Name (If not institution, give street and number) Mediplex Of Montgomery Village | | | | 4b. City, Town, or Location of Death Gaithersburg | | 4c. County of Death Montgomery | |
| Funeral Director | 5. Social Security Number 579-32-9934 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 70 | | 8. Date of Birth (Month, Day, Year) Nov. 4, 1927 | |
| | 9. Birthplace (State or Foreign Country) Cambridge, MA | | 10a. State VA | | 10b. County Fairfax | | 10c. City, Town or Location Fairfax | |
| Usual Residence of Decedent | | | | | | | | |
| 10e. Street and Number 10837 Broadwater Drive | | | | 10f. Zip Code 22032 | | 10g. Citizen of What Country? U.S.A. | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) +4 College (1-4or 5+) | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker | | | 16b. Kind of Business/Industry Own Home | | |
| 17. Father's Name (First, Middle, Last) Malcolm Callahan | | | | | 18. Mother's Name (First, Middle, Maiden Surname) Mary Lee Dodson | | | |
| 19a. Informant's Name/Relationship (Type, Print) Wade H. Atkinson, Sr. Husband | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10837 Broadwater Drive, Fairfax, VA 22032 | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Rock Creek Cemetery | | Date 12/11/97 | | 20c. Location - City or Town, State Washington, D.C. | |
| 21. Signature of Funeral Service Licensee | | | | | 22. Name and Address of Facility Joseph Gawler's Sons, Inc. 5130 WI Avenue, N.W. Washington, D.C. 20016 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | Approximate Interval Between Onset and Death |
| Immediate Cause (Final disease or condition resulting in death) Perforated Viscous | | | | | | | | 3 days |
| Due to (or as a consequence of): Chronic Steroid Therapy | | | | | | | | 1 year |
| Due to (or as a consequence of): end Stage Asthma | | | | | | | | 2 years |
| Due to (or as a consequence of): | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Dementia | | | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how Injury occurred |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier | | | | 29c. License number D33443 | | 29d. Date signed (Month, Day, Year) December 9, 1997 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Alan Pollack, M.D. 809 viers Mill Road, Rockville, MD 20852 | | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 10 1997 | | | 32. Registrar's Signature | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

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Physician
/Medical
Examiner

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38802

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ESTHER L. BAUMAN

2. Date of Death

Month Day Year
DEC 4 1997

3. Time of Death

11:28A

4a. Facility Name (If not institution, give street and number)

SUBURBAN HOSPITAL

4b. City, Town, or Location of Death

BETHESDA

4c. County of Death

MONTGOMERY

Funeral
Director

5. Social Security Number

356-20-2313

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

85 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

MARCH 5, 1912

9. Birthplace (State or Foreign Country)

ILLINOIS

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

MONTGOMERY

10c. City, Town or Location

ROCKVILLE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

10201 GROSVENOR PLACE #1202

10f. Zip Code

20852

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

TEACHER

16b. Kind of Business/Industry

HIGH SCHOOL

17. Father's Name (First, Middle, Last)

LEO SCHY

18. Mother's Name (First, Middle, Maiden Surname)

AUGUSTA EARTH

19a. Informant's Name/Relationship (Type, Print)

PHILIP BAUMAN/HUSBAND

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10201 GROSVENOR PLACE #1202, ROCKVILLE, MD 20852

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☒ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

KING DAVID MEMORIAL GDNS 12/7/97 FALLS CHURCH, VIRGINIA

Data

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

EDWARD SAGEL FUNERAL DIRECTION, INC.

10901 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

Pulmonary Embolism
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

4 hrs.

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Dementia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?
1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient2 ☒ Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D21115

29d. Date signed (Month, Day, Year)

12/4/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Lee R. Pennington, MD 5602 Shields Drive, Bethesda, MD 20817

31. Date filed (Month, Day, Year)

DEC 8 1997

32. Registrar's Signature

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 23a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

State
Registrar

97 38803

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) PAULINE P. BEST | | | | 2. DATE OF DEATH MONTH DAY YEAR December 8, 1997 | | 3. TIME OF DEATH 2:11 PM | |
| 4. SOCIAL SECURITY NUMBER 578-22-1033 | | 5. SEX 1 <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 85 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) March 15, 1912 | |
| 8. BIRTHPLACE (State or Foreign Country) Maryland | | | | 9. COUNTY OF DEATH Montgomery | | | |
| 9a. FACILITY NAME (If not institution, give street and number) Washington Adventist Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Takoma Park | | 9c. COUNTY OF DEATH Montgomery | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE Maryland | | 10b. COUNTY Prince George's | | 10c. CITY, TOWN OR LOCATION Beltsville | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 4112 Kenny Street | | | | 10f. ZIP CODE 20705 | | 10g. CITIZEN OF WHAT COUNTRY? United States | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 4 | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Teacher | | 16b. KIND OF BUSINESS/INDUSTRY Prince George's Co. Schools | |
| 17. FATHER'S NAME (First, Middle, Last) George Melvin Phillips | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Emma Washington Huffington | | | |
| 19a. INFORMANT'S NAME (Type/Print) Ellen R. Anderson (Daughter) | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8455 Heatherwood Drive Laurel, Maryland 20723 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) George Washington Cemetery 12/12/1997 Adelphi, Maryland | | 20c. LOCATION — City or Town, State | | 20d. DATE | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Donald V. Borgwardt | | | | 22. NAME AND ADDRESS OF FACILITY Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Road Beltsville, Maryland 20705 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | a. SEVERE PULMONARY INSUFFICIENCY 2 WEEKS DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | b. TRACHEOBRONCHITIS and ASTHMA YEARS DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| | | c. RESTRICTIVE LUNG DISEASE YEARS DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| | | d. | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CORONARY ARTERY DISEASE RENAL FAILURE | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE NOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 28g. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER John P. M.D. | | | | 29c. LICENSE NUMBER D 18551 | | 29d. DATE SIGNED (Month, Day, Year) 12/8/97 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) SAMIR NEIMAT, MD. 7610 CARROLL AV. TAKOMA PARK, MD, 20912 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) DEC 12 1997 | | | | 32. REGISTRAR'S SIGNATURE Julia Davidson-Randall | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

17-18-19

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **97 38804**
Certificate of Death

Reg. No.

Physician
/Medical
Examiner

Funeral
Director

| | | | | | | | |
|--|--|---|--|--|--------------------------------|--|--|
| 1. Decedent's Name (First, Middle, Last) Bernard Biederman | | | | 2. Date of Death Month Dec. 7, Day 1997 Year | | 3. Time of Death 8:10am | |
| 4a. Facility Name (If not institution, give street and number) Montgomery General Hospital | | | | 4b. City, Town, or Location of Death Olney | | 4c. County of Death Montgomery | |
| 5. Social Security Number 021-20-1017 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 83 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) Nov. 18, 1914 | |
| 9. Birthplace (State or Foreign Country) Massachusetts | | | | | | | |
| Usual Residence of Decedent | | | | | | | |
| 10a. State MD | | 10b. County Montgomery | | 10c. City, Town or Location Silver Spring | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10e. Street and Number 3227 Bel Pre Road | | | | 10f. Zip Code 20906 | | 10g. Citizen of What Country? USA | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Contractor | | 16b. Kind of Business/Industry Painting | |
| 17. Father's Name (First, Middle, Last) Morris Biederman | | | | 18. Mother's Name (First, Middle, Maiden Surname) Emma Duboft | | | |
| 19a. Informant's Name/Relationship (Type, Print) Richard M. Biederman-son | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8905 Heatherwood Ct. Potomac, MD 20854 | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Judean Mem. Gardens | | Date 12/9/97 | | 20c. Location - City or Town, State Olney, MD | |
| 21. Signature of Funeral Service Licensee  | | | | 22. Name and Address of Facility Edward Sagel Funeral Direction 1091 Rockville Pike Rockville MD 20852 | | | |
| 23a. Part, Error, the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Bilateral Pneumonia Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | | | | | | |
| Approximate Interval Between Onset and Death 2 weeks | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. History of Cerebro-vascular accident History of Atrial Fibrillation | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. Describe how Injury occurred | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| 29b. Signature and title of certifier William J. Ninala | | | | 29c. License number D45285 | | 29d. Date signed (Month, Day, Year) December 7, 1997 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) W.J. Ninala, MD 18111 Prince Phillip Dr. Suite 212 Olney, MD 20832 | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 12 1997 | | | | 32. Registrar Signature  | | | |

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38805

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

Theresa Marlene Blankenship

2. Date of Death

Month Day Year
December 9, 1997 2:37 pm

3. Time of Death

4a. Facility Name (If not institution, give street and number)

WASHINGTON ADVENTIST HOSPITAL

4b. City, Town, or Location of Death

TAKOMA PARK

4c. County of Death

MONTGOMERY

5. Social Security Number

205-26-7460

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

63

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
AUG. 9, 1934

9. Birthplace (State or Foreign Country)

PA.

Usual Residence of Decedent

10e. State

MD.

10b. County

PRINCE GEORGES

10c. City, Town or Location

HYATTSVILLE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

4907 EASTERN AVE. #314

10f. Zip Code

20782

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

9

College (14 or 5+)

16. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

RESIDENT MANAGER

16b. Kind of Business/Industry

APARTMENTS

17. Father's Name (First, Middle, Last)

FRANCIS BOBKO

18. Mother's Name (First, Middle, Maiden Surname)

MARY SCHRABAN

19a. Informant's Name/Relationship (Type, Print)

THERESA M. BLANKENSHIP/SELF

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

SAME AS ITEM #10

20e. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

CHAMBERS CREMATORY

Date

12/9/97

20c. Location - City or Town, State

RIVERDALE, MD.

21. Signature of Funeral Service Licensee

W. W. Chambers

M00091

22. Name and Address of Facility

CHAMBERS FUNERAL HOMES, P.A., RIVERDALE, MD. 20737

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Stroke

Approximate Interval Between Onset and Death

3 days

e. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

XX Inpatient

2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)

XX

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

T. S. Anthony

29c. License number

D50300

29d. Date signed (Month, Day, Year)

December 9, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

T.J. Anthony, M.D. 11119 Rockville Pike, #316 Rockville, MD 20952

31. Date filed (Month, Day, Year)

DEC 11 1997

32. Registrar's Signature

Julia Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **97 38806**
Certificate of Death

Reg. No.

| | | | | | | | | |
|---|--|---|---|--|--|---|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) MARGARET BOSZORMENYI | | | | 2. Date of Death Month DECEMBER Day 7 Year 1997 | | 3. Time of Death 6:20 PM | |
| | 4a. Facility Name (If not institution, give street and number) COLLINGSWOOD NURSING CENTER | | | | 4b. City, Town, or Location of Death ROCKVILLE | | 4c. County of Death MONTGOMERY | |
| Funeral Director | 5. Social Security Number 223-40-7380 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 96 Yrs. | | 8. Date of Birth (Month, Day, Year) Apr. 2, 1901 | |
| | 9. Birthplace (State or Foreign Country) Hungary | | 10a. State Maryland | | 10b. County Montgomery | | 10c. City, Town or Location Rockville | |
| To Be Completed by Funeral Director | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number 299 Hurley Avenue | | 10f. Zip Code 20850 | | 10g. Citizen of What Country? United States | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Accountant | | 16b. Kind of Business/Industry Accounting | | | |
| | 17. Father's Name (First, Middle, Last) Unknown | | | | 18. Mother's Name (First, Middle, Maiden Surname) Unknown | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Rev. Joseph P. Zalotay, Priest | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6701 Muncaster Mill Road, Derwood, MD 20855 | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Olivet Cemetery | | Date 12/11 1997 | | 20c. Location - City or Town, State Washington, DC | |
| | 21. Signature of Funeral Service Licensee <i>[Signature]</i> | | | | 22. Name and Address of Facility DeVol Funeral Home 10 E. Deer Park Drive, Gaithersburg, MD 20877 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Acute Cerebrovascular accident Due to (or as a consequence of): b. Chronic hypertension Due to (or as a consequence of): c. Chronic cardiac arrhythmias Due to (or as a consequence of): d. | | | | Approximate Interval Between Onset and Death 24 hrs | | | |
| | 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 23c. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | |
| | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier Hiru S. Khianey MD | | | | 29c. License number D22978 | | 29d. Date signed (Month, Day, Year) December 8, 1997 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hiru Khianey, M.D., 19520 Doctors Drive, Germantown, MD 20874-5200 | | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 10 1997 | | 32. Registrar's Signature <i>[Signature]</i> | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38807

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

BEATRICE VIRGINIA BROOKS

2. Date of Death

December 8, 1997

3. Time of Death

10:40AM

4a. Facility Name (If not institution, give street and number)

Washington Adventist Hospital

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

5. Social Security Number

224-48-4236

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

86

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

April 15, 1911

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

MD

10b. County

Prince Georges

10c. City, Town or Location

Adelphi

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1801 Metzertott Road

10f. Zip Code

20783

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☐ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: Black

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

3

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Home

17. Father's Name (First, Middle, Last)

Unobtainable

18. Mother's Name (First, Middle, Maiden Surname)

Blanche Williams

19a. Informant's Name/Relationship (Type, Print)

Iretha B. Clark, Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2310 Fairview Terrace Alexandria, Va. 22303

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

2nd Baptist Church Cem.

Date

12/15/97

20c. Location - City or Town, State

Falls Church, Va.

21. Signature of Funeral Service Licensee

Bernard Amer

22. Name and Address of Facility

Ames Funeral Home, Inc.

8914 Quarry Road Manassas, Virginia 20110

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a. Sudden Congestive Heart Failure

Due to (or as a consequence of):

b. SEPSIS / Bronchopneumonia

Due to (or as a consequence of):

c. Renal Failure

Due to (or as a consequence of):

d. Respiratory Failure

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Atrial Fibrillation

Hypertension

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending2 ☐ Accident

Investigation

3 ☐ Suicide6 ☐ Could not be4 ☐ Homicide

determined

28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

A Rao MD

29c. License number

D 20757

29d. Date signed (Month, Day, Year)

12.9.97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

A Rao S. Rao

8100 Good Luck Road, Suite 302
Lanham, Maryland 20707

31. Date filed (Month, Day, Year)

DEC 11 1997

32. Registrar's Signature

Julia Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 38808

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

FELIX BRANHAM

2. Date of Death

Month 12 Day 9 Year 97

3. Time of Death

9:25 AM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Holy Cross Hospital

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

5. Social Security Number

230-09-5231

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

76 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
July 5, 1921

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2203 Greenery Lane, #104

10f. Zip Code

20906

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give
Year or Dates: WW II13. Was Decedent of Hispanic Origin? (Specify Yes or No.
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
5

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Self-employed

16b. Kind of Business/Industry

Carpentry

17. Father's Name (First, Middle, Last)

Battle Branham

18. Mother's Name (First, Middle, Maiden Surname)

Maude Pritchett

19a. Informant's Name/Relationship (Type, Print)

Nita Branham / Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2203 Greenery Lane, #104, Silver Spring, Maryland 20906

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Arlington National Cem. 12/18/97 Arlington, Virginia

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Lauri J. Holland

22. Name and Address of Facility

Hines-Rinaldi Funeral Home
11800 New Hampshire Avenue
Silver Spring, Maryland 2090423a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

CARDIAC ARREST

a.

Due to (or as a consequence of):

METABOLIC ACIDOSIS

b.

Due to (or as a consequence of):

RENAL FAILURE

c.

Due to (or as a consequence of):

Non-Hodgkin's Lymphoma

d.

Approximate
Interval Between
Onset and Death

5 min.

4 days

12 hrs

2 days

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of causa
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☐ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

S. J. Holland

29c. License number

D10660

29d. Date signed (Month, Day, Year)

12/18/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

EDGAR H. LEVIN ; 4701 GEORGETOWN AVE, SILVER SPRING

31. Date filed (Month, Day, Year)

DEC 12 1997

32. Registrar's Signature

Julia Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

to the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10+1

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38809

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Frank Brucella

2. Date of Death

Month Day Year
December 8, 1997

3. Time of Death

10:20 AM

Funeral
Director

4e. Facility Name (If not institution, give street and number)

Suburban Hospital

4b. City, Town, or Location of Death

Bethesda

4c. County of Death

Montgomery

5. Social Security Number

079-22-8867

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

90 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Nov. 23, 1907

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

Md.

10b. County

Montgomery

10c. City, Town or Location

Rockville

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

199 Rollins Ave.

10f. Zip Code

20852

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Navar Married ☒ Married☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

☒ Yes ☐ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Driver

16b. Kind of Business/Industry

Dept. of Sanitation
New York City

17. Father's Name (First, Middle, Last)

Donato Brucella

18. Mother's Name (First, Middle, Maiden Surname)

Rosa Viola

19a. Informant's Name/Relationship (Type, Print)

Blanche Brucella (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

199 Rollins Ave. Apt. 230 Rockville, Md. 20852

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Chambers Crematory

Date

12/10/97 Riverdale, Md.

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Thomas S. Chambers # 670

22. Name and Address of Facility

Chambers Funeral Homes P.A.
5801 Cleveland Ave. Riverdale, Md. 20737

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Respiratory Failure

Due to (or as a consequence of):

b. Perforated Sigmoid Colon

Due to (or as a consequence of):

c. Diverticulitis

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☐ Yes ☐ No

26. Place of Death (Check only one)

Hospital:

☒ Inpatient☐ ER/Outpatient☐ DOA

Other:

☐ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Accident☐ Suicide☐ Homicide☐ Pending Investigation☐ Could not be determined☐ Pending Investigation☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☐ No

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☐ No

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☐ No

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☐ No

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☐ No

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☐ No

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☐ No

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☐ No

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☐ No

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☐ No

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☐ No

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☐ No

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☐ No

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☐ No

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☐ No

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☐ No

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☐ No

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☐ No

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☐ No

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☐ No

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☐ No

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☐ No

31. Date filed (Month, Day, Year)

DEC 10 1997

32. Registrar's Signature

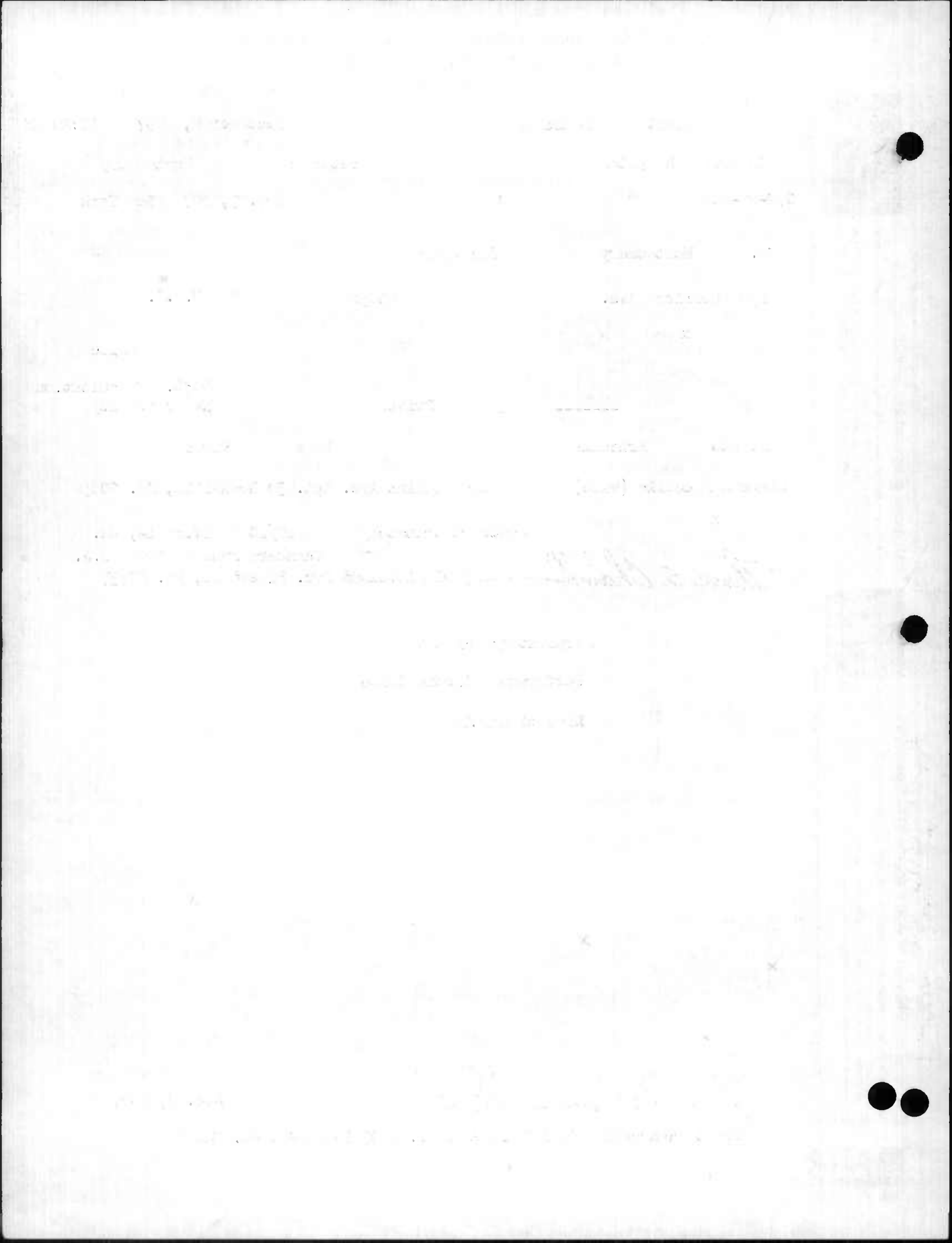
John Davidson-Randall

State Registrar

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38810

Physician
/Medical
Examiner

Funeral
Director

1. Decedent's Name (First, Middle, Last)

JEROME ALBERT BRUSSELL

2. Date of Death
Month Day Year

DEC. 8 1997

3. Time of Death

7:08am

4a. Facility Name (If not institution, give street and number)

Washington Adventist Hospital

4b. City, Town, or Location of Death

Takoma Park

4c. County of Death

Montgomery

5. Social Security Number

578-16-0952

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

88 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

Oct. 15, 1909

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Takoma Park

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

7227 Minter Place

10f. Zip Code

20912

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

1

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Illustrator

16b. Kind of Business/Industry

Federal Government

17. Father's Name (First, Middle, Last)

Maxwell Brussell

18. Mother's Name (First, Middle, Maiden Surname)

Esther Ratner

19a. Informant's Name/Relationship (Type, Print)

Dolly Marie Brussell / Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7227 Minter Place, Takoma Park, Maryland 20912

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

George Washington Cem. 12/12/97 Adelphi, Maryland

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Shirley Caporale

22. Name and Address of Facility

Hines-Rinaldi Funeral Home
11800 New Hampshire Avenue
Silver Spring, Maryland 20904

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Congestive heart failure
Due to (or as a consequence of):

b. coronary artery disease
Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Cerebrovascular disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient

2 ☒ ER/Outpatient

3 ☐ DOA

Other:

4 ☐ Nursing Home

5 ☐ Residence

6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

David M. Brill MD

29c. License number

D36601

29d. Date signed (Month, Day, Year)

12/04/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

DAVID M. BRILL, MD 7600 CARROLL AVE, TAKOMA PARK MD 20912

31. Date filed (Month, Day, Year)

DEC 10 1997

32. Registrar's Signature

John Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38811

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Virginia Hust Burazer

2. Date of Death

Month Day Year
Dec 8, 1997

3. Time of Death

01:15pm

4a. Facility Name (If not institution, give street and number)

Holy Cross Hospital

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

212-03-6231

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

86 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Nov. 19, 1911

9. Birthplace (State or Foreign Country)

Washington, DC

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

703 Tanley Road

10f. Zip Code

20904

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Henry Hust

18. Mother's Name (First, Middle, Maiden Surname)

Gertrude Koch

19a. Informant's Name/Relationship (Type, Print)

Robert Coyne (attorney)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

400 University Blvd. West, Silver Spring, MD 20901

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Forest

Date

12/11/97

20c. Location - City or Town, State

Silver Spring, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Francis J. Collins Funeral
Home, Inc. 500 University Blvd. West
Silver Spring, MD 2090123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a.

perforated viscus - sepsis
small bowel obstruction

Due to (or as a consequence of):

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
2 ☐ Accident investigation
3 ☐ Suicide 6 ☐ Could not be
4 ☐ Homicide determined28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

Dec 9, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Bradley H. Bennett MD 2440 M St NW Washington DC 20037

31. Date filed (Month, Day, Year)

DEC 10 1997

32. Registrar's Signature

J. Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38812

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Edward A. Burgoon

2. Date of Death

Month Day Year
December 7, 1997

3. Time of Death

7:55 AM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Magnolia Gardens Nursing Home

4b. City, Town, or Location of Death

Lanham

4c. County of Death

Prince George's

5. Social Security Number

193-10-6149

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

78

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
December 20, 1918

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10e. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Greenbelt

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

37-K Ridge Road

10f. Zip Code

20770

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give

Year or Dates:

1940-

1945

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No

Specify:

14. Race - American Indian, Black, White, etc.

Specify:

White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16e. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Property Manager

16b. Kind of Business/Industry

Real Estate

17. Father's Name (First, Middle, Last)

Edward Alonzo Burgoon

18. Mother's Name (First, Middle, Maiden Surname)

Agnes Lennon

19e. Informant's Name/Relationship (Type, Print)

Barbara Burgoon

(wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

37-K Ridge Road, Greenbelt, Maryland 20770

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Chesapeake Crematory

Date

12-8-97

20c. Location - City or Town, State

Beltsville, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Rapp Funeral Services, P.A.

933 Gist Avenue, Silver Spring, Maryland 20910

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cardiopulmonary Arrest

Due to (or as a consequence of):

b. Acute Myocardial Infarction

Due to (or as a consequence of):

c. Atherosclerosis

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

Immediate

Years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Previous Cerebrovascular Accident

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24e. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28e. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D37934

29d. Date signed (Month, Day, Year)

12/8/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Stephanie Trifoglio, M.D.

7500 Greenway Center Dr. #430 Greenbelt, MD 20770

31. Date filed (Month, Day, Year)

DEC 08 1997

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

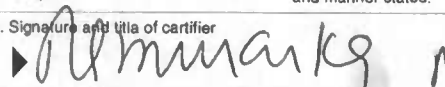
State of Maryland / Department of Health and Mental Hygiene

Amend #18,19b,12/11/97,BMW, Montg. Co

Certificate of Death

Reg. No.

97 38813

| | | | | | | | | |
|---|--|---|---|--|--|---|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Stella B. Balzer | | | | 2. Date of Death Month Dec , Day 4 , Year 1997 | | 3. Time of Death 2:55pm | |
| | 4a. Facility Name (If not institution, give street and number) SHADY GROVE ADVENTIST HOSPITAL | | | | 4b. City, Town, or Location of Death ROCKVILLE | | 4c. County of Death MONTGOMERY | |
| Funeral Director | 5. Social Security Number 065-03-9536 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 86 Yrs. | | 8. Date of Birth (Month, Day, Year) Aug. 18, 1911 | |
| | 9. Birthplace (State or Foreign Country) Austria | | 10a. State MD | | 10b. County Montgomery | | 10c. City, Town or Location Gaithersburg | |
| To Be Completed by Funeral Director | Usual Residence of Decedent | | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| | 10e. Street and Number 19310 Clubhouse Road | | | | 10f. Zip Code 20879 | | 10g. Citizen of What Country? USA | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Beautician | | 16b. Kind of Business/Industry Beauty Parlor | | | |
| | 17. Father's Name (First, Middle, Last) Anton Billovits | | | | 18. Mother's Name (First, Middle, Maiden Surname) Julia (Ukraine) Tamedl | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Frank Billovits (Unknown) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1902 Mason Hill Dr. Alexandria CA 22307 | | | |
| | 20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) St. Raymonds Cem | | Date 12/8/97 | | 20c. Location - City or Town, State Bronx, NY | |
| | 21. Signature of Funeral Service Licensee  Daniel Simons | | | | 22. Name and Address of Facility Edward Sagel Funeral Direction 1091 Rockville Pike Rockville, MD 20852 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Cardiac Arrest Due to (or as a consequence of): b. Acute Cerebrovascular Accident Due to (or as a consequence of): c. Chronic Atrial Fibrillation Due to (or as a consequence of): d. | | | | Approximate Interval Between Onset and Death 3-5 days | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Dementia | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 28d. Describe how Injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier  R. Murarka M.D. | | | | 29c. License number D29816 | | 29d. Date signed (Month, Day, Year) December 4, 1997 | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) R. MURARKA 13900 NATIA MANOR DR. N. POTOMAC, MD 20878 | | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 11 1997 | | 32. Registrar's Signature  | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

1. The first part of the document is a list of names and addresses.

2. The second part of the document is a list of names and addresses.

3. The third part of the document is a list of names and addresses.

4. The fourth part of the document is a list of names and addresses.

5. The fifth part of the document is a list of names and addresses.

6. The sixth part of the document is a list of names and addresses.

7. The seventh part of the document is a list of names and addresses.

8. The eighth part of the document is a list of names and addresses.

9. The ninth part of the document is a list of names and addresses.

10. The tenth part of the document is a list of names and addresses.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 38814

Certificate of Death

Reg. No.

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|--|--|--|--|--|---|---|--|---|----|---|----------------|----------------------------------|--|--|----|---|---------------|----------------------------------|--|--|--|----|--|------------------|----------------------------------|--|--|----|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) CLARENCE B. CROWE, JR. | | | | 2. Date of Death Month Day Year December 9 1997 | | 3. Time of Death 12:20PM | | | | | | | | | | | | | | | | | | | | | | | | |
| | 4a. Facility Name (If not institution, give street and number) ST. MARY'S HOSPITAL | | | | 4b. City, Town, or Location of Death LEONARDTOWN | | 4c. County of Death ST. MARY'S | | | | | | | | | | | | | | | | | | | | | | | | |
| Funeral Director | 5. Social Security Number 217-24-9643 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (in yrs. last birthday) 69 Yrs. | | 8. Date of Birth (Month, Day, Year) FEB. 27, 1928 | | | | | | | | | | | | | | | | | | | | | | | | |
| | 9. Birthplace (State or Foreign Country) MARYLAND | | 10a. State MARYLAND | | 10b. County ST. MARY'S | | 10c. City, Town or Location MECHANICSVILLE | | | | | | | | | | | | | | | | | | | | | | | | |
| To Be Completed by Funeral Director | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number 27605 BAPTIST CHURCH ROAD | | 10f. Zip Code 20659 | | 10g. Citizen of What Country? U.S.A. | | | | | | | | | | | | | | | | | | | | | | | | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1946-1947 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | | | | | | | | | | | | | | | | | | | | | | | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) INSPECTOR/PLANNER | | 16b. Kind of Business/Industry PEPCO | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 17. Father's Name (First, Middle, Last) CLARENCE B. CROWE, SR. | | | | 18. Mother's Name (First, Middle, Maiden Surname) ANNE LOU POPES | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print) RUTH S. CROWE/WIFE | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27605 BAPTIST CHURCH ROAD, MECHANICSVILLE, MD 20659 | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) TRINITY MEMORIAL GARDENS | | 20c. Location - City or Town, State WALDORF, MARYLAND | | 20d. Date DEC. 12, 1997 | | | | | | | | | | | | | | | | | | | | | | | | |
| | 21. Signature of Funeral Service Licensee <i>Mark G. Brohawn</i> MARK G. BROHAWN MO0053 | | 22. Name and Address of Facility THE HUNTT FUNERAL HOME, INC. P.O. BOX 156, WALDORF, MARYLAND 20604 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 23a. Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 23b. Approximate Interval Between Onset and Death | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | <table border="0"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a.</td> <td><i>Irreversible Adult Respiratory Distress Syndrome</i></td> <td><i>54+ hrs</i></td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>b.</td> <td><i>Post-op Males Abdominopelvic Resection of Rectum</i></td> <td><i>7 days</i></td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td rowspan="2">Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</td> <td>c.</td> <td><i>INVASIVE Adenocarcinoma of Rectum Distal B T1N0M0</i></td> <td><i>6+ months</i></td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td colspan="2">d.</td> <td></td> <td></td> </tr> </table> | | | | | | | | Immediate Cause (Final disease or condition resulting in death) | a. | <i>Irreversible Adult Respiratory Distress Syndrome</i> | <i>54+ hrs</i> | Due to (or as a consequence of): | | | b. | <i>Post-op Males Abdominopelvic Resection of Rectum</i> | <i>7 days</i> | Due to (or as a consequence of): | | | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | c. | <i>INVASIVE Adenocarcinoma of Rectum Distal B T1N0M0</i> | <i>6+ months</i> | Due to (or as a consequence of): | | | d. | | |
| Immediate Cause (Final disease or condition resulting in death) | a. | <i>Irreversible Adult Respiratory Distress Syndrome</i> | <i>54+ hrs</i> | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | Due to (or as a consequence of): | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | b. | <i>Post-op Males Abdominopelvic Resection of Rectum</i> | <i>7 days</i> | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | Due to (or as a consequence of): | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | c. | <i>INVASIVE Adenocarcinoma of Rectum Distal B T1N0M0</i> | <i>6+ months</i> | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | Due to (or as a consequence of): | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| d. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Old Post-Traumatic L-1 Paraplegia</i> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | | | | | | | | | | | | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 29b. Signature and title of certifier <i>John N. Roache, MD, FACS</i> | | 29c. License number D15027 | | 29d. Date signed (Month, Day, Year) Dec 9-1997 | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <i>John N. Roache, MD, FACS, P.O. Box 186, MECHANICSVILLE, Md. 20659</i> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 12 1997 | | 32. Registrar's Signature <i>John Andrew Randall</i> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

CLARENCE BRYANT CROWE

Division of Vital Records, P.O. Box 68760,

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend #5, 12/16/97, BMW, Montg. Co.

Certificate of Death

Reg. No.

97 38815

| | | | | | |
|---|--|--|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) SARA COHEN | | 2. Date of Death Month: DECEMBER Day: 6, Year: 1997 | | 3. Time of Death 12:45 AM |
| | 4a. Facility Name (If not institution, give street and number) HEBREW HOME OF GREATER WASHINGTON | | 4b. City, Town, or Location of Death ROCKVILLE | | 4c. County of Death MONTGOMERY |
| Funeral Director | 5. Social Security Number 159-03-2677 | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 94 Yrs. | 8. Date of Birth (Month, Day, Year) NOV. 27, 1903 | 9. Birthplace (State or Foreign Country) LONDON, ENGLAND |
| | Usual Residence of Decedent | | | | |
| To Be Completed by Funeral Director | 10a. State MARYLAND | 10b. County MONTGOMERY | 10c. City, Town or Location ROCKVILLE | | 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |
| | 10e. Street and Number 6105 MONTROSE ROAD | | 10f. Zip Code 20852 | | 10g. Citizen of What Country? UNITED STATES |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever In U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |
| | 14. Race - American Indian, Black, White, etc. Specify: WHITE | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12): 12 Collage (1-4 or 5+) | | |
| | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) OWNER | | 16b. Kind of Business/Industry RETAIL GROCERY STORE | | |
| | 17. Father's Name (First, Middle, Last) JACOB LANSMAN | | 18. Mother's Name (First, Middle, Maiden Surname) GERTRUDE LIPSCHITZ | | |
| | 19a. Informant's Name/Relationship (Type, Print) ROBERT EPSTEIN (NEPHEW) | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1615 AUBURN AVENUE - ROCKVILLE, MARYLAND 20850 | | |
| | 20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) MT. COMFORT CREMATORY | | 20c. Location - City or Town, State 12/11/97 ALEXANDRIA, VIRGINIA |
| | 21. Signature of Funeral Service Licensee <i>Frank A. Struel</i> | | 22. Name and Address of Facility DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE - ROCKVILLE, MARYLAND 20852 | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | |
| Physician /Medical Examiner | Immediate Cause (Final disease or condition resulting in death) | | a. CEREBROVASCULAR DISEASE | | 5 YEARS |
| | Due to (or as a consequence of): | | b. GENERALIZED ARTERIO SCLEROSIS | | 4 YEARS |
| | Due to (or as a consequence of): | | c. | | |
| | Due to (or as a consequence of): | | d. | | |
| | Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CARCINOMA OF BREAST | | | | |
| | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | | |
| | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | |
| | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M |
| 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how Injury occurred | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | |
| 29b. Signature and title of certifier <i>Steven Lipson MD</i> | | 29c. License number D 05885 | | 29d. Date signed (Month, Day, Year) 12/6/97 | |
| 30. Name and address of person who completed causa of death (Item 23a) (Type, Print) STEVEN LIPSON 6121 MONTROSE ROAD, ROCKVILLE | | | | | |
| State Registrar | 31. Date filed (Month, Day, Year) DEC 08 1997 | | 32. Registrar's Signature <i>Julia Davidson-Randall</i> | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38816

| | | | | | | | | | | | | | | | | | | | | |
|---|---|---|--|--|--|--|---|---|----|-----------------|---------|----|----------------------------------|--|----|----------------------------------|--|----|----------------------------------|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Thomas Joseph Carolan | | | | 2. Date of Death Month Day Year December 8, 1997 | | 3. Time of Death 7:00 AM | | | | | | | | | | | | | |
| | 4a. Facility Name (If not institution, give street and number) 1545 Live Oak Drive | | | | 4b. City, Town, or Location of Death Silver Spring | | 4c. County of Death Montgomery | | | | | | | | | | | | | |
| Funeral Director | 5. Social Security Number 216-44-9242 | | 6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 89 Yrs. | | 8. Date of Birth (Month, Day, Year) May 24, 1908 | | | | | | | | | | | | | |
| | 9. Birthplace (State or Foreign Country) New York | | 10a. State MD | | 10b. County Montgomery | | 10c. City, Town or Location Silver Spring | | | | | | | | | | | | | |
| 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 10e. Street and Number 1545 Live Oak Drive | | 10f. Zip Code 20910 | | 10g. Citizen of What Country? USA | | | | | | | | | | | | | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | | | | | | | | | | | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) U.S. Foreign Service | | 16b. Kind of Business/Industry Federal Government | | | | | | | | | | | | | | | | |
| 17. Father's Name (First, Middle, Last) Philip Carolan | | | | 18. Mother's Name (First, Middle, Maiden Surname) Mary Catherine Farley | | | | | | | | | | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Thomas J. Carolan, Jr. (son) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1513 Red Oak Drive, Silver Spring, MD 20910 | | | | | | | | | | | | | | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Gate of Heaven Cemetery | | 20c. Date 12/11/97 | | 20d. Location - City or Town, State Silver Spring, MD | | | | | | | | | | | | | | |
| 21. Signature of Funeral Service Licensee Stevenson D. Starn | | | | 22. Name and Address of Facility Francis J. Collins Funeral Home, Inc. 500 University Blvd. West Silver Spring, MD 20901 | | | | | | | | | | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | | | | | | | | | |
| <table border="0"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death) Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last </td> <td>a.</td> <td>Aortic Stenosis</td> <td>5 years</td> </tr> <tr> <td>b.</td> <td>Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>c.</td> <td>Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>d.</td> <td>Due to (or as a consequence of):</td> <td></td> </tr> </table> | | | | | | | | Immediate Cause (Final disease or condition resulting in death) Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. | Aortic Stenosis | 5 years | b. | Due to (or as a consequence of): | | c. | Due to (or as a consequence of): | | d. | Due to (or as a consequence of): | |
| Immediate Cause (Final disease or condition resulting in death) Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. | Aortic Stenosis | 5 years | | | | | | | | | | | | | | | | | |
| | b. | Due to (or as a consequence of): | | | | | | | | | | | | | | | | | | |
| | c. | Due to (or as a consequence of): | | | | | | | | | | | | | | | | | | |
| | d. | Due to (or as a consequence of): | | | | | | | | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | | | | | | | | |
| | | | | | | 24e. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | | | | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | | | | | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | | | | | | |
| | | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | | | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | | | | | | | | | | | |
| 29b. Signature and title of certifier George F. Sengstack M.D. | | | | 29c. License number D12121 | | 29d. Date signed (Month, Day, Year) December 8, 1997 | | | | | | | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) George F. Sengstack 3929 Ferrara Drive, Wheaton, MD 20906 | | | | | | | | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 09 1997 | | 32. Registrar's Signature Julia Davidson-Rendell | | | | | | | | | | | | | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Walter Everett Carter

2. Date of Death

Month Day Year
Dec. 7, 1997

3. Time of Death

2:55 p.m.

4a. Facility Name (If not institution, give street and number)

9001 Congressional Court

4b. City, Town, or Location of Death

Potomac

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

577-07-3077

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

96

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Sept. 29, 1901

9. Birthplace (State or Foreign Country)

Washington, DC

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Potomac

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

9001 Congressional Court

10f. Zip Code

20854-4608

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married

3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever In U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates:

WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

+4

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Business Executive

16b. Kind of Business/Industry

Manufacturing, Ice cream

Automobile Dealership

17. Father's Name (First, Middle, Last)

William Golden Carter

18. Mother's Name (First, Middle, Maiden Surname)

Margaret Jane Espey

19a. Informant's Name/Relationship (Type, Print)

William Pennington nephew

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9100 Kensington Parkway, Chevy Chase, MD 20815

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Rock Creek Cemetery

Date

12/11/97

20c. Location - City or Town, State

Washington, D.C.

21. Signature of Funeral Service Licensee

Shirley Peters

22. Name and Address of Facility

Joseph Gawler's Sons, Inc. 5130 WI Avenue, N.W. Washington, D.C. 20016

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Prostate Carcinoma

Approximate Interval Between Onset and Death

9 years

e. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Atrial Fibrillation

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural

2 ☐ Accident

3 ☐ Suicide

4 ☐ Homicide

5 ☐ Pending investigation

6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician

2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Lee R. Pennington, M.D.

29c. License number

D 21115

29d. Date signed (Month, Day, Year)

December 7, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Lee R. Pennington, M.D. 5602 Shields Drive, Bethesda, MD 20817

State
Registrar

31. Date filed (Month, Day, Year)

DEC 11 1997

32. Registrar's Signature

Jill Davidson-Randall

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 2 should be detached for use as the burial-transit card.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 38818

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|---|---|--|--|---|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) NICKY CHAN | | | | 2. Date of Death Month Day Year DECEMBER 9, 1997 | | 3. Time of Death 5:30 AM | |
| | 4a. Facility Name (If not institution, give street and number) 16005 BONNIEBANK TERRACE | | | | 4b. City, Town, or Location of Death DARNESTOWN | | 4c. County of Death MONTGOMERY | |
| Funeral Director | 5. Social Security Number 587-40-7588 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 62 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) NOV. 11, 1935 | 9. Birthplace (State or Foreign Country) CHINA |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State MARYLAND | | 10b. County MONTGOMERY | | 10c. City, Town or Location DARNESTOWN | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10e. Street and Number 16005 BONNIEBANK TERRACE | | | | 10f. Zip Code 20874 | | 10g. Citizen of What Country? UNITED STATES | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: ASIAN | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5+ | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) CHEMIST | | 16b. Kind of Business/Industry U.S. GOVERNMENT | | |
| 17. Father's Name (First, Middle, Last) WONG-YAM CHAN | | | | 18. Mother's Name (First, Middle, Maiden Surname) HELEN (YEF) FUNG | | | | |
| 19a. Informant's Name/Relationship (Type, Print) CHRISTINA CHAN (WIFE) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16005 BONNIEBANK TERRACE - DARNESTOWN, MARYLAND 20874 | | | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) MT. COMFORT CREMATORY | | Date 12/15/97 | | 20c. Location - City or Town, State ALEXNDRIA, VIRGINIA | | |
| 21. Signature of Funeral Service Licensee  | | | | 22. Name and Address of Facility DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. METASTATIC COLORECTAL CANCER Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | | | | | | | Approximate Interval Between Onset and Death 18 MONTHS |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| | | | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier  | | 29c. License number D32407 | | 29d. Date signed (Month, Day, Year) DECEMBER 9, 1997 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. JOSEPH HAGGERTY, 10605 CONCORD STREET #300, KENSINGTON, MARYLAND 20895-2594 | | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 11 1997 | | 32. Registrar's Signature  | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

87 38819

Physician
/Medical
Examiner

| | | | | |
|--|--|--|--------------------------------|--|
| 1. Decedent's Name (First, Middle, Last) <u>YI YIEN CHANG</u> | | 2. Date of Death Month <u>November</u> Day <u>24</u> Year <u>1997</u> | | 3. Time of Death <u>6:10 pm</u> |
| 4a. Facility Name (If not institution, give street and number) WASHINGTON ADVENTIST HOSPITAL | | 4b. City, Town, or Location of Death TAKOMA PARK | | 4c. County of Death PRINCE GEORGES |
| 5. Social Security Number 214.70.2031 | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 86 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. |
| 8. Date of Birth (Month, Day, Year) NOV 21, 1911 | | 9. Birthplace (State or Foreign Country) KEELUNG CHINA | | |

Funeral
Director

| | | | | |
|-----------------------------|----------------------------------|---|--|--|
| Usual Residence of Decedent | | 10c. City, Town or Location SILVER SPRING | | 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |
| 10a. State MD | 10b. County MONTGOMERY | | | |

| | | |
|---|-------------------------------|--|
| 10e. Street and Number 14227 CASTLE BLVD. | 10f. Zip Code 20904 | 10g. Citizen of What Country? U.S.A. |
|---|-------------------------------|--|

| | | | |
|--|---|--|---|
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | 14. Race - American Indian, Black, White, etc. Specify: ASIAN |
|--|---|--|---|

| | | |
|---|---|---|
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 2 | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) PRACTICAL NURSE | 16b. Kind of Business/Industry HOSPITAL |
|---|---|---|

| | |
|--|--|
| 17. Father's Name (First, Middle, Last) SHOI CHIH LING | 18. Mother's Name (First, Middle, Maiden Surname) SHIN FU TSAI |
|--|--|

| | |
|---|--|
| 19a. Informant's Name/Relationship (Type, Print) EMILY MOORE / DAUGHTER | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 143 AMBERLEIGH DR. SILVER SPRING MD. 20905 |
|---|--|

| | | | |
|---|---|-------------------------|---|
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | 20b. Place of Disposition (Name of cemetery, crematory or other place) GATE OF HEAVEN | Date 11/29/97 | 20c. Location - City or Town, State SILVER SPRING MD. |
|---|---|-------------------------|---|

| | |
|--|--|
| 21. Signature of Funeral Service Licensee <i>[Signature]</i> M859 | 22. Name and Address of Facility POPE FUNERAL HOMES 11315 LOCKWOOD BR. S/S MD. |
|--|--|

| | | |
|--|--|--|
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. <u>Perforation of large intestine</u> Due to (or as a consequence of): b. <u>Cachexia</u> Due to (or as a consequence of): c. <u>Anorexia</u> Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | Approximate Interval Between Onset and Death <u>1 day</u> |
|--|--|--|

| | | |
|--|--|--|
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Chronic Aneurysm</u> <u>Abnormal liver function</u> <u>possible cholangitis</u> | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |
| | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |
| | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |

| | | |
|---|---|--|
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury M |
| | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | 28d. Describe how injury occurred |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |

| |
|---|
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |
|---|

| | | |
|---|---------------------------------------|--|
| 29b. Signature and title of certifier <i>[Signature]</i> | 29c. License number D 26707 | 29d. Date signed (Month, Day, Year) 11-25-97 |
|---|---------------------------------------|--|

| |
|---|
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Tung Pi LEE MD 700 Buckingham Dr. Silver Spring MD 20901 |
|---|

| | |
|---|---|
| 31. Date filed (Month, Day, Year) DEC 08 1997 | 32. Registrar's Signature <i>[Signature]</i> |
|---|---|

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38820

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Yuting Wu Chen

2. Date of Death

Month Day Year
December 6, 1997

3. Time of Death

11:00 AM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

7102 Copernicus Lane

4b. City, Town, or Location of Death

Lanham

4c. County of Death

Prince George's

5. Social Security Number

215-31-3454

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

89 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

February 22, 1908

9. Birthplace (State or Foreign Country)

Foochow, China

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Lanham

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7102 Copernicus Lane

10f. Zip Code

20706

10g. Citizen of What Country?

China

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: Asian

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Kwan Yi Wu

18. Mother's Name (First, Middle, Maiden Surname)

Lei Ying Chen

19a. Informant's Name/Relationship (Type, Print)

Manie Chen

(daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7102 Copernicus Lane, Lanham, MD 20706

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Chesapeake Crematory

Date

12-8-97

20c. Location - City or Town, State

Beltsville, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Rapp Funeral Services, P.A.

933 Gist Avenue, Silver Spring, Maryland 20910

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a. Painless Jaundice

Due to (or as a consequence of):

6 weeks

b. Biliary Obstruction

Due to (or as a consequence of):

6 weeks

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending

Investigation

6 ☐ Could not be

determined

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 ☐11 ☐12 ☐13 ☐14 ☐15 ☐16 ☐17 ☐18 ☐19 ☐20 ☐21 ☐22 ☐23 ☐24 ☐25 ☐26 ☐27 ☐28 ☐29 ☐30 ☐31 ☐32 ☐33 ☐34 ☐35 ☐36 ☐37 ☐38 ☐39 ☐40 ☐41 ☐42 ☐43 ☐44 ☐45 ☐46 ☐47 ☐48 ☐49 ☐50 ☐51 ☐52 ☐53 ☐54 ☐55 ☐56 ☐57 ☐58 ☐59 ☐60 ☐61 ☐62 ☐63 ☐64 ☐65 ☐66 ☐67 ☐68 ☐69 ☐70 ☐71 ☐72 ☐73 ☐74 ☐75 ☐76 ☐77 ☐78 ☐79 ☐80 ☐81 ☐82 ☐83 ☐84 ☐85 ☐86 ☐87 ☐88 ☐89 ☐90 ☐91 ☐92 ☐93 ☐94 ☐95 ☐96 ☐97 ☐98 ☐99 ☐100 ☐101 ☐102 ☐103 ☐104 ☐105 ☐106 ☐107 ☐108 ☐109 ☐110 ☐111 ☐112 ☐113 ☐114 ☐115 ☐116 ☐117 ☐118 ☐119 ☐120 ☐121 ☐122 ☐123 ☐124 ☐125 ☐126 ☐127 ☐128 ☐129 ☐130 ☐131 ☐132 ☐133 ☐134 ☐135 ☐136 ☐137 ☐138 ☐139 ☐140 ☐141 ☐142 ☐143 ☐144 ☐145 ☐146 ☐147 ☐148 ☐149 ☐150 ☐151 ☐152 ☐153 ☐154 ☐155 ☐156 ☐157 ☐158 ☐159 ☐160 ☐161 ☐162 ☐163 ☐164 ☐165 ☐166 ☐167 ☐168 ☐169 ☐170 ☐171 ☐172 ☐

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38821

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

PEGGY J. CLARK

2. Date of Death

Month
DEC.

Day

7,

Year
1997

3. Time of Death

5:30 PM

4a. Facility Name (If not institution, give street and number)

MONTGOMERY GENERAL HOSPITAL

4b. City, Town, or Location of Death

OLNEY

4c. County of Death

MONTGOMERY

Funeral
Director

5. Social Security Number

579-58-5326

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

55

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

AUG. 13, 1942

9. Birthplace (State or Foreign Country)

NEBRASKA

Usual Residence of Decedent

10a. State

NE.

10b. County

DOUGLAS

10c. City, Town or Location

OMAHA

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3542 NORTH 36th AVE.

10f. Zip Code

68111

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: BLACK

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12

College (1-4 or 5+)

18a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

TECHNICIAN

16b. Kind of Business/Industry

INSURANCE CO.

17. Father's Name (First, Middle, Last)

CHRISTMAN CLARK

18. Mother's Name (First, Middle, Maiden Surname)

DOROTHY STEVENS

19a. Informant's Name/Relationship (Type, Print)

PATRICIA BAKER/SISTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

40 LONGFELLOW ST. N.E., WASHINGTON, D.C. 20011

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

CHAMBERS CREMATORY 12/11/97 RIVERDALE, MD.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

M00091

22. Name and Address of Facility

SILVER SPRING, MD.

CHAMBERS FUNERAL HOMES, P.A.

20910

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

Gram Negative and Vancomycin Resistant

Approximate
Interval Between
Onset and Death

2 weeks

Due to (or as a consequence of):

Enterococcal Sepsis

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Last

Due to (or as a consequence of):

Pneumonia

2 weeks

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

Insulin Dependent Diabetes Mellitus

Sacral Decubiti

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation
6 ☐ Could not be determined28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Wilkinson J. Nivala

29c. License number

D45285

29d. Date signed (Month, Day, Year)

December 8, 1997

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

18111 Prince Phillip Dr., Suite 212, Olney, Md 20832

31. Date filed (Month, Day, Year)

DEC 11 1997

32. Registrar's Signature

Julia Davidson-Rodriguez

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

3

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 38822

| | | | | | | | | | |
|---|---|--|---|--|--|---|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) VIOLA DOROTHY DIX | | | | 2. Date of Death Month Day Year Dec. 10, 1997 | | 3. Time of Death 11:40 PM | | |
| | 4a. Facility Name (If not institution, give street and number) PHYSICIANS MEMORIAL HOSPITAL | | | | 4b. City, Town, or Location of Death La Plata | | 4c. County of Death Charles | | |
| Funeral Director | 5. Social Security Number 578- 38-9491 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 67 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) JULY 19, 1930 | 9. Birthplace (State or Foreign Country) VIRGINIA | |
| | Usual Residence of Decedent | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State MARYLAND | | 10b. County CHARLES | | 10c. City, Town or Location WALDORF | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | 10e. Street and Number 3907 OLD WASHINGTON ROAD | | | | 10f. Zip Code 20602 | | 10g. Citizen of What Country? UNITED STATES | | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4or 5+) 0 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) COMPUTER EQUIPMENT ANALYST | | 16b. Kind of Business/Industry U.S. GOVERNMENT | | | | |
| | 17. Father's Name (First, Middle, Last) ROBERT WILLIAM PUSEY, SR. | | | | 18. Mother's Name (First, Middle, Maiden Surname) MARIE A. BECK | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) DEBRA L. RICE - DAUGHTER | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3762 OLD WASHINGTON RD., WALDORF, MD. 20602 | | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) TRINITY MEM. GARDENS, DECEMBER 15, 1997 WALDORF, MD. | | Date | | 20c. Location - City or Town, State | | |
| | 21. Signature of Funeral Service Licensee MARK G. BROHAWN MO0053 | | 22. Name and Address of Facility THE HUNTT FUNERAL HOME, INC. P.O. BOX 156, WALDORF, MARYLAND 20604 | | | | | | |
| | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | |
| 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) TRANSITIONAL CARE UNIT | | | | | | | | | |
| 27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how Injury occurred | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | |
| 29b. Signature and title of certifier Dr. LAAW Attending | | | | 29c. License number D44436 | | 29d. Date signed (Month, Day, Year) DEC 11 1997 | | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) ASHVINKUMAR J PATEL 6B PRESTON SQUARE II INDUSTRIAL PARK WALDORF MD 20601 | | | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 12 1997 | | | | 32. Registrar's Signature J. H. Harrison | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38823

| | | | | | | | | | | | | | | | | | | | |
|--|--|--------------------------|---|---|---|--------------------------|---|--|--|---|----|--------------------------|----------------------------------|----|---------------|----|-----------|----|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Louis Davila | | | | 2. Date of Death Month Day Year December 5, 1997 | | | | 3. Time of Death 3:05 AM | | | | | | | | | | |
| | 4a. Facility Name (If not institution, give street and number) Howard County General Hospital | | | | 4b. City, Town, or Location of Death Columbia | | | | 4c. County of Death Howard | | | | | | | | | | |
| Funeral Director | 5. Social Security Number 095-26-3910 | | 6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 62 Yrs. | | 8. Date of Birth (Month, Day, Year) Sept. 22, 1935 | | 9. Birthplace (State or Foreign Country) New York | | | | | | | | | | |
| | Usual Residence of Decedent | | | | | | | | | | | | | | | | | | |
| 10a. State MD | | 10b. County Howard | | 10c. City, Town or Location Clarksville | | | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | | | |
| 10e. Street and Number 11298 Old Hopkins Road | | | | 10f. Zip Code 21029 | | | | 10g. Citizen of What Country? USA | | | | | | | | | | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 1954-1957 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No Specify: Puerto Rican | | | 14. Race - American Indian, Black, White, etc. Specify: White | | | | | | | | | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Sales Representative | | | | 16b. Kind of Business/Industry Wholesale | | | | | | | | | | | |
| 17. Father's Name (First, Middle, Last) Luis Davila | | | | 18. Mother's Name (First, Middle, Maiden Surname) Celia Mendoza | | | | | | | | | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Dolores Davila (wife) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11298 Old Hopkins Road, Clarksville, MD 21029 | | | | | | | | | | | | | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Gate of Heaven Cemetery | | Date 12/8/97 | | 20c. Location - City or Town, State Silver Spring, MD | | | | | | | | | | | |
| 21. Signature of Funeral Service Licensee Tracy A. Stuever | | | | 22. Name and Address of Facility Francis J. Collins Funeral Home, Inc. 500 University Blvd. West Silver Spring, MD 20901 | | | | | | | | | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | | | | | | | | |
| <table border="0"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a.</td> <td>Ventricular Fibrillation</td> <td rowspan="4">Due to (or as a consequence of):</td> </tr> <tr> <td>b.</td> <td>Cor Pulmonale</td> </tr> <tr> <td>c.</td> <td>Emphysema</td> </tr> <tr> <td>d.</td> <td></td> </tr> </table> | | | | | | | | | | Immediate Cause (Final disease or condition resulting in death) | a. | Ventricular Fibrillation | Due to (or as a consequence of): | b. | Cor Pulmonale | c. | Emphysema | d. | |
| Immediate Cause (Final disease or condition resulting in death) | a. | Ventricular Fibrillation | Due to (or as a consequence of): | | | | | | | | | | | | | | | | |
| | b. | Cor Pulmonale | | | | | | | | | | | | | | | | | |
| | c. | Emphysema | | | | | | | | | | | | | | | | | |
| | d. | | | | | | | | | | | | | | | | | | |
| 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Asthma | | | | | | | | | | | | | | | | | | | |
| 23c. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | | | | | | | | | | | | | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | | | | | | | | | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | | | |
| | | | | 28d. Describe how injury occurred | | | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | | | | | | | | | |
| 29b. Signature and title of certifier [Signature] | | | | 29c. License number D19252 | | | | 29d. Date signed (Month, Day, Year) December 5, 1997 | | | | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Roberto A. Depetris, M.D., 14300 Gallant Fox Lane, #122, Bowie, MD 20715 | | | | | | | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 10 1997 | | | | 32. Registrar's Signature [Signature] | | | | | | | | | | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **97 38824**
Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ARTHUR DAVID DAVIS

2. Date of Death

Month Day Year
DECEMBER 09, 1997

3. Time of Death

08:50AM
FOUND

4a. Facility Name (If not institution, give street and number)

6013 CIPRIANO ROAD

4b. City, Town, or Location of Death

SEABROOK

4c. County of Death

PRINCE GEORGES

Funeral
Director

5. Social Security Number

229-66-2018

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

50 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
NOV. 22, 1947

9. Birthplace (State or Foreign Country)

PA.

Usual Residence of Decedent

10e. State

MD.

10b. County

PRINCE GEORGES

10c. City, Town or Location

SEABROOK

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

6013 CIPRIANO RD.

10f. Zip Code

20706

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: WHITE

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16e. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

PODIATRIAST

16b. Kind of Business/Industry

MEDICINE

17. Father's Name (First, Middle, Last)

ARTHUR D. DAVIS JR.

18. Mother's Name (First, Middle, Maiden Surname)

RUTH UNKNOWN

19a. Informant's Name/Relationship (Type, Print)

DONNA CHERNISKY/FRIEND

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3401 FORSYTHYA LA., BURTONSVILLE, MD. 20866

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

CHAMBERS CREMATORY

Date

12/11/97

20c. Location - City or Town, State

RIVERDALE, MD.

21. Signature of Funeral Service Licensee

W. W. Chambers M00091

22. Name and Address of Facility

CHAMBERS FUNERAL HOMES, P.A., RIVERDALE, MD. 20737

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

e. CARBON MONOXIDE INTOXICATION

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify)

PARKING LOT

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☒ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation
6 ☐ Could not be
determined

28e. Date of injury

(Month, Day, Year)
12-09-9728b. Time of
injury08:50AM
FOUND28c. Injury at
Work?1 ☐ Yes 2 ☒ No28e. Place of injury - At home, farm, street, factory, office
building, etc. (Specify)

PARKING LOT

28d. Describe how injury occurred
SUBJECT CONNECTED HOSE TO AUTO
EXHAUST INTO INSIDE OF AUTO28f. Location (Street and Number or Rural Route Number,
City or Town, State)

6013 CIPRIANO ROAD, SEABROOK, MARYLAND

29a. Certifier
(Check only
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

Mario F. Golle Jr MD

29c. License number

D 33954

29d. Date signed (Month, Day, Year)

DECEMBER 10, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MARIO F. GOLLE JR MD 3001 HOSPITAL DRIVE, CHEVERLY, MARYLAND 20785

State
Registrar

31. Date filed (Month, Day, Year)

DEC 11 1997

32. Registrar's Signature

Julia Anderson-Rodriguez

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 38825

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Chester A. Dailey, Sr.

2. Date of Death

Month Day Year
December 9, 1997

3. Time of Death

10:58 AM

4a. Facility Name (If not institution, give street and number)

15 Jefferson Avenue

4b. City, Town, or Location of Death

Takoma Park

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

213-05-0700

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

81

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Jan. 4, 1916

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Takoma Park

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

15 Jefferson Avenue

10f. Zip Code

20912

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No.
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
6

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Carpentry

16b. Kind of Business/Industry

Construction

17. Father's Name (First, Middle, Last)

Arthur L. Dailey

18. Mother's Name (First, Middle, Maiden Surname)

Mary Helen Kindred

19a. Informant's Name/Relationship (Type, Print)

Mary Helen Thomas / Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10706 Judy Lane, Columbia, Maryland 21044

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Fort Lincoln Cemetery

Date

12/12/97

20c. Location - City or Town, State

Brentwood, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Hines-Rinaldi Funeral Home
11800 New Hampshire Avenue
Silver Spring, Maryland 2090423a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a.

Due to (or as a consequence of):

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) LastApproximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?
1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation
6 ☐ Could not be determined28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

DEC 12 1997

32. Registrar's Signature

Julia Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38826

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Anthony Richard DeFelice

2. Date of Death

Month Day Year
December 8, 1997

3. Time of Death

9:45 PM

Funeral
Director

4a. Facility Name (If not Institution, give street and number)

Suburban Hospital

4b. City, Town, or Location of Death

Bethesda

4c. County of Death

Montgomery

5. Social Security Number

216-44-3205

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

86 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Nov. 20, 1911

9. Birthplace (State or Foreign Country)

New Jersey

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Bethesda

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7822 Glenbrook Road

10f. Zip Code

20814

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Attorney

16b. Kind of Business/Industry

U.S. Government

17. Father's Name (First, Middle, Last)

John DeFelice

18. Mother's Name (First, Middle, Maiden Surname)

Mary Cachillo

19a. Informant's Name/Relationship (Type, Print)

Richard J. DeFelice/ Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

14 Kings Grant Road, Hockessin, Delaware 19707

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☒ Other (Specify) Entombment20b. Place of Disposition (Name of
cemetery, crematory or other place)

Gate of Heaven Mausoleum

Date

Dec. 12, 1997

20c. Location - City or Town, State

Silver Spring, Maryland

21. Signature of Funeral Service Licensee

000689

22. Name and Address of Facility Robert A. Pumphrey Funeral Home/
Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue
Bethesda, Maryland 20814-350123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or want failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)a. Cardiogenic Shock

Due to (or as a consequence of):

36 hours

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Lastb. Extensive Anterior Myocardial Infarction

Due to (or as a consequence of):

36 hours

c. _____
Due to (or as a consequence of):d. _____
Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Acute Renal Failure

Chronic Glomerulonephritis

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of causa
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
2 ☐ Accident investigation
3 ☐ Suicide 6 ☐ Could not be
4 ☐ Homicide determined

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Roger Stevenson, M.D.

29c. License number

D20535

29d. Date signed (Month, Day, Year)

December 9, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Roger Stevenson, M.D. 6410 Rockledge Drive, #200, Bethesda, Maryland 20817

31. Date filed (Month, Day, Year)

DEC 12 1997

32. Registrar's Signature

Julia Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38827

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Panagiotis E. Dousikos

2. Date of Death

December 5, 1997

3. Time of Death

9:00 AM

4a. Facility Name (If not institution, give street and number)

Holy Cross Hospital

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

216-64-6423

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

62 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Sept. 6, 1935

9. Birthplace (State or Foreign Country)

Greece

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

13709 Beret Place

10f. Zip Code

20906

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Owner

16b. Kind of Business/Industry

Restaurant

17. Father's Name (First, Middle, Last)

Efthimios Dousikos

18. Mother's Name (First, Middle, Maiden Surname)

Maria Mamalios

19a. Informant's Name/Relationship (Type, Print)

Metaxia S. Dousikos (wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

13709 Beret Place, Silver Spring, MD 20906

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Gate of Heaven Cemetery

Date

12/8/97

20c. Location - City or Town, State

Silver Spring, MD

21. Signature of Funeral Service Licensee

Tracy A. Shur.

22. Name and Address of Facility Francis J. Collins Funeral Home, Inc. 500 University Blvd. West Silver Spring, MD 20901

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Due to (or as a consequence of):

Coronary artery Disease years

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient2 ☒ Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

John Sander MD

29c. License number

D08546

29d. Date signed (Month, Day, Year)

Dec. 8 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

John Tauber 8218 Wisconsin Ave Bethesda Md.

31. Date filed (Month, Day, Year)

DEC 09 1997

32. Registrar's Signature

Julia Davidson-Rodriguez

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38828

| | | | | | | | | | | | | | |
|--|--|---|---|--|--|--|---|--|---|--|---|-------------------------------------|-------------------------------------|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Donald Duckworth | | | | 2. Date of Death Month December Day 8 Year 1997 | | 3. Time of Death 11:20 PM | | | | | | |
| | 4a. Facility Name (If not Institution, give street and number) Manor Care-Chevy Chase | | | | 4b. City, Town, or Location of Death Chevy Chase | | 4c. County of Death Montgomery | | | | | | |
| Funeral Director | 5. Social Security Number 215-26-0604 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (in yrs. last birthday) 68 Yrs. | If Under 1 Year Months | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) August 12, 1929 | 9. Birthplace (State or Foreign Country) Michigan | | | | | |
| | Usual Residence of Decedent | | | | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State Maryland | | 10b. County Montgomery | | 10c. City, Town or Location Silver Spring | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| | 10e. Street and Number 10000 Brunswick Avenue #116 | | | | 10f. Zip Code 20910 | | 10g. Citizen of What Country? United States | | | | | | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | | | | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4 or 5+) 4 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Salesman | | | 16b. Kind of Business/Industry Marketing | | | | | | | |
| | 17. Father's Name (First, Middle, Last) Henry Duckworth | | | | 18. Mother's Name (First, Middle, Maiden Surname) Janet Mary Cross | | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) Dorothy Yarrington/ Sister | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 327 Dean Drive Rockville, Maryland 20851 | | | | | | | | |
| | 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Montgomery Crematorium Inc. | | 20c. Location - City or Town, State Bethesda, Maryland | | 20d. Date December 11, 1997 | | | | | | |
| | 21. Signature of Funeral Service Licensee  M00335 | | | | 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501 | | | | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | |
| | <table border="1"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last </td> <td>a. Colon Cancer with metastatic disease</td> <td rowspan="4">Approximate Interval Between Onset and Death Months</td> </tr> <tr> <td>b. Due to (or as a consequence of):</td> </tr> <tr> <td>c. Due to (or as a consequence of):</td> </tr> <tr> <td>d. Due to (or as a consequence of):</td> </tr> </table> | | | | | | | | Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. Colon Cancer with metastatic disease | Approximate Interval Between Onset and Death Months | b. Due to (or as a consequence of): | c. Due to (or as a consequence of): |
| Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. Colon Cancer with metastatic disease | Approximate Interval Between Onset and Death Months | | | | | | | | | | | |
| | b. Due to (or as a consequence of): | | | | | | | | | | | | |
| | c. Due to (or as a consequence of): | | | | | | | | | | | | |
| | d. Due to (or as a consequence of): | | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | |
| | | 28d. Describe how injury occurred | | | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier  | | 29c. License number D33357 | | 29d. Date signed (Month, Day, Year) 12/9/97 | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Lee Jonathan Musher, M.D. 5530 Wisconsin Ave. #1045, Chevy Chase, Maryland 20815 | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 12 1997 | | 32. Registrar's Signature  | | | | | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

3

State
Registrar

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38829

| | | | | | | | | | |
|--|--|---|---|---|--|---|---|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) John Edgar Eaton | | | | 2. Date of Death Month Dec. Day 6, Year 1997 | | 3. Time of Death 8:18 A.M. | | |
| | 4a. Facility Name (If not institution, give street and number) Suburban Hospital | | | | 4b. City, Town, or Location of Death Bethesda | | 4c. County of Death Montgomery | | |
| Funeral Director | 5. Social Security Number 033-30-0855 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 58 Yrs. | | 8. Date of Birth (Month, Day, Year) Apr. 29, 1939 | | |
| | 9. Birthplace (State or Foreign Country) Massachusetts | | 10a. State M.D. | | 10b. County Montgomery | | 10c. City, Town or Location Bethesda | | |
| Usual Residence of Decedent | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number 7800 English Way | | 10f. Zip Code 20817 | | 10g. Citizen of What Country? U.S.A. | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 5+ College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Clinical Chemist | | 16b. Kind of Business/Industry Clinical Laboratory | | 17. Father's Name (First, Middle, Last) John Edgar Eaton II | | 18. Mother's Name (First, Middle, Maiden Surname) Bessie Rowley | |
| 19a. Informant's Name/Relationship (Type, Print) Delores N. Eaton - Wife | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7800 English Way Bethesda, Md. 20817 | | 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Mount Comfort Crematory | | 20c. Location - City or Town, State 12/8/97 Alexandria, Va. | |
| 21. Signature of Funeral Service Licensee | | 22. Name and Address of Facility Joseph Gawler's Sons 5130 Wisc. Ave. N.W. Washington, D.C. 20016 | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last a. Ischemic Cardiomyopathy Due to (or as a consequence of): b. Hyperlipemia Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | Approximate Interval Between Onset and Death 10 years 20 years | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. End Stage Renal Disease | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) M | | 28b. Time of Injury 1 Yes <input type="checkbox"/> No | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier | | 29c. License number D21340 | | 29d. Date signed (Month, Day, Year) Dec. 8, 1997 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Raymond Bass, M.D. 15225 Shady Grove Road, #302 Rockville, MD 20850 | | 31. Date filed (Month, Day, Year) DEC 10 1997 | | 32. Registrar's Signature | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or item 23a or 23a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

15

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38830

| | | | | | | | | | |
|---|--|---|--|---|---|--|---|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Paul E. Ertzinger | | | | 2. Date of Death Month Day Year Dec. 2 1997 | | 3. Time of Death 11:25 PM | | |
| | 4a. Facility Name (If not institution, give street and number) Rockville Nursing Home | | | | 4b. City, Town, or Location of Death Rockville | | 4c. County of Death Montgomery | | |
| Funeral Director | 5. Social Security Number 577-60-0822 | | 6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 86 Yrs. | | 8. Date of Birth (Month, Day, Year) Sept. 26, 1911 | | |
| | 9. Birthplace (State or Foreign Country) Indiana | | 10a. State MD | | 10b. County Montgomery | | 10c. City, Town or Location Rockville | | |
| Usual Residence of Decedent | | 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 10e. Street and Number 12108 Whipporwill Lane | | 10f. Zip Code 20852 | | 10g. Citizen of What Country? USA | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 5 + | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Special Agent | | 16b. Kind of Business/Industry Federal Bureau of Investigation | | | | | |
| 17. Father's Name (First, Middle, Last) Albert L. Ertzinger | | | | 18. Mother's Name (First, Middle, Maiden Surname) Eva Hansen | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Carolyn B. Ertzinger - Wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12108 Whipporwill Lane Rockville, MD 20852 | | | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Parklawn Cemetery | | Date 12/6/97 | | 20c. Location - City or Town, State Rockville, MD | |
| 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility Joseph Gawler's Sons 5130 Wisc. Ave. N.W. Washington, D. C. 20016 | | | | | |
| 23a. Pert. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. Myocardial Infarction Due to (or as a consequence of): b. Arteriosclerotic Heart Disease Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death Sudden 10 Years | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Bladder Cancer Metastatic to Hip Charcot-Marie-Tooth Neuropathy | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | 29b. Signature and title of certifier | | | | 29c. License number D 15049 | |
| | | | | 29d. Date signed (Month, Day, Year) December 3, 1997 | | | | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) John Gustafson, M. D. 5480 Wisconsin Ave. #1625 Chevy Chase, MD 20815 | | | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 08 1997 | | 32. Registrar's Signature | | | | | | | |

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

person. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 23a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit

MISSING

DEATH

certificate no.: 97-38830

DEATH

DL-38830

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38831

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

William Lindy Fields

2. Date of Death

Month Day Year
December 8, 1997

3. Time of Death

11:45 PM

4a. Facility Name (If not institution, give street and number)

Mariner Health Care of Silver Spring

4b. City, Town, or Location of Death

Wheaton

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

578-28-4248

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

70 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
May 22, 1927

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Rockville

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1103 Veirs Mill Road

10f. Zip Code

20851

10g. Citizen of What Country?

United States

11. Marital Status

1 ☒ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: Korea

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Stone Mason

16b. Kind of Business/Industry

Contractor

17. Father's Name (First, Middle, Last)

John Joseph Fields

18. Mother's Name (First, Middle, Maiden Surname)

Myrtle Irene Spong

19a. Informant's Name/Relationship (Type, Print)

Margaret E. Corbin/Sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Route 2, Box 408 Kearneysville, West Virginia 25430

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Potomac United Methodist Church Cemetery

Date

Dec. 11, 1997

20c. Location - City or Town, State

Potomac, Maryland

21. Signature of Funeral Service Licensee

M00198

22. Name and Address of Facility

Robert A. Pumphrey Funeral Home/Rockville, Inc.
300 West Montgomery Avenue
Rockville, Maryland 20850-2805

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Pyriform Sinus Cancer

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

6 months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D09834

29d. Date signed (Month, Day, Year)

December 9, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Barry N. Rosenbaum, M.D. 3720 Farragut Avenue, Kensington, Maryland 20895-2110

31. Date filed (Month, Day, Year)

DEC 10 1997

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 38832

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|---|---|--|--|---|--|--|---|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) SUSAN G. GAL-EDD | | | | 2. Date of Death Month Day Year DEC. 01, 1997 | | 3. Time of Death 7:59pm. | |
| | 4a. Facility Name (If not institution, give street and number) 11801 DINWIDDIE DR. | | | | 4b. City, Town, or Location of Death ROCKVILLE | | 4c. County of Death MONTGOMERY | |
| Funeral Director | 5. Social Security Number 145-48-2746 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 44 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) Mar. 30, 1953 | 9. Birthplace (State or Foreign Country) NJ |
| | Usual Residence of Decedent | | | | | | | |
| 10e. State MD | | 10b. County Montgomery | | 10c. City, Town or Location Rockville | | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| 10e. Street and Number 11801 Dinwiddie Drive | | | | 10f. Zip Code 20856 | | 10g. Citizen of What Country? USA | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 5+ | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Teacher | | | 16b. Kind of Business/Industry Special Education | |
| 17. Father's Name (First, Middle, Last) Irving Weiss | | | | 18. Mother's Name (First, Middle, Maiden Surname) Shirley Shapiro | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Irving Weiss-father | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15115 Interlachen Dr. #203 Silver Spring, MD 20906 | | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Judean Memorial Gardens | | 20c. Location - City or Town, State 12/3/97 Olney, MD | | |
| 21. Signature of Funeral Service Licensee  | | | | 22. Name and Address of Facility Edward Sagel Funeral Direction 1091 Rockville Pike Rockville, MD 20852 | | | | |
| 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. metastatic gastric cancer Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred |
| | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier  | | 29c. License number DC A655 | | 29d. Date signed (Month, Day, Year) 12/2/97 | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) JOHN MARSHALL, MD 3800 RESERVOIR RD NW WASHINGTON DC 20007 | | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 08 1997 | | 32. Registrar's Signature  | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38833

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Daryl R. Gibson Jr.

2. Date of Death

November 30, 1997

3. Time of Death

7:10 Pm

4a. Facility Name (If not institution, give street and number)

NATIONAL SECURITY AGENCY BLDG.

4b. City, Town, or Location of Death

FT. MEADE

4c. County of Death

ANNE ARUNDEL

Funeral
Director

5. Social Security Number

620-01-9768

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

21

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

DEC. 18, 1975

9. Birthplace (State or Foreign Country)

CALIFORNIA

Usual Residence of Decedent

10a. State

MD.

10b. County

ANNE ARUNDEL

10c. City, Town or Location

FT. MEADE

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

BLDG. 9827 ROOM 320B

10f. Zip Code

20755

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☒ Never Married ☐ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever In U.S. Armed Forces?

☒ Yes ☐ No
If Yes, Give Year or Dates: ACTIVE DUTY

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

U.S. AIR FORCE

16b. Kind of Business/Industry

DEFENSE

17. Father's Name (First, Middle, Last)

DARYL R. GIBSON SR.

18. Mother's Name (First, Middle, Maiden Surname)

NYDIA IBANEZ

19a. Informant's Name/Relationship (Type, Print)

DARYL R. GIBSON SR./FATHER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12031-3 WORLD TRADE DR., SAN DIEGO, CAL. 91218

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

CHAMBERS CREMATORY

Date

12/5/97

20c. Location - City or Town, State

RIVERDALE, MD.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

M00091 CHAMBERS FUNERAL HOMES, P.A., RIVERDALE, MD. 20737

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. MULTIPLE TRAUMATIC INJURIES

SECONDS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☒ Yes ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

☒ Yes ☐ No

25. Was case referred to medical examiner?

☒ Yes ☐ No

Hospital:

☐ Inpatient☐ ER/Outpatient☐ DOA

Other:

☐ Nursing Home☐ Residence☒ Other (Specify)

GOV BLDG

27. Manner of Death

☐ Natural ☐ Pending investigation
☐ Accident ☐ Could not be determined
☒ Suicide ☐ Homicide

28a. Date of Injury (Month, Day Year)

NOV 30 1997

28b. Time of Injury

7:10 PM

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

JUMP FROM HEIGHT

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

GOV'T BLDG (STAIRWELL)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

FORT MEADE, MD

29e. Certifier (Check only one)

☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

ASSOCIATE ARMED FORCES MEDICAL EXAM

29c. License number

D34086

29d. Date signed (Month, Day, Year)

DEC 5, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

STEPHEN L. ROBINSON, AFIP 1413 RESEARCH BLVD, ROCKVILLE, MD

31. Date filed (Month, Day, Year)

DEC 08 1997

32. Registrar's Signature

Julia Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

AL. 007. 100-100-100

100-100-100

100-100-100

100-100-100

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38834

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Charles Dwight Green

2. Date of Death

Month Day Year
December 7, 1997

3. Time of Death

8:15AM

4a. Facility Name (If not institution, give street and number)

Randolph Hills Nursing Center

4b. City, Town, or Location of Death

Wheaton

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

187-07-3632

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

89 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Sept. 28, 1908

9. Birthplace (State or Foreign Country)

Kansas

Usual Residence of Decedent

10e. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Wheaton

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

4011 Randolph Road

10f. Zip Code

20902

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Freight Traffic Consultant

16b. Kind of Business/Industry

Freight Traffic

17. Father's Name (First, Middle, Last)

Charles Dudley Green

18. Mother's Name (First, Middle, Maiden Surname)

Vivian Studebaker

19a. Informant's Name/Relationship (Type, Print)

Rosalie A. Stroube/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1013 E Street, S.E. Washington, D.C. 20003

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Montgomery Crematorium, Inc.

Date

December 8, 1997

20c. Location - City or Town, State

Bethesda, Maryland

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

Robert A. Pumphrey Funeral Home/
Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue
Bethesda, Maryland 20814-3501

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Alzheimer's Dementia

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. _____
Due to (or as a consequence of):c. _____
Due to (or as a consequence of):d. _____
Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Urosepsis, Gastrointestinal BleedingSenile Inanition

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)

1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

D08944

29d. Date signed (Month, Day, Year)

December 8, 1997

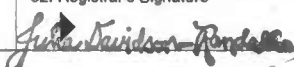
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Martin C. Shargel, M.D. 3720 Farragut Avenue, Kensington, Maryland 20895-2110

31. Date filed (Month, Day, Year)

DEC 10 1997

32. Registrar's Signature


State
Registrar

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38835

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Bernie DeHaven Hall

2. Date of Death

Month Day Year
DECEMBER 6, 1997

3. Time of Death

10:00 AM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

SOUTHERN MARYLAND HOSPITAL

4b. City, Town, or Location of Death

CLINTON

4c. County of Death

PRINCE GEORGE'S

5. Social Security Number

404-30-6658

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

70 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
MARCH 6, 1927

9. Birthplace (State or Foreign Country)

KENTUCKY

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

CHARLES

10c. City, Town or Location

WALDORF

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

13840 BALLANTRAE LANE

10f. Zip Code

20601

10g. Citizen of What Country?

UNITED STATES

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: 1952-1955

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12College (1-4 or 5+)
0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

COMPUTER ANALYST

16b. Kind of Business/Industry

UNITED STATES AIR FORCE

17. Father's Name (First, Middle, Last)

DAVID EDGAR HALL

18. Mother's Name (First, Middle, Maiden Surname)

LENA MYRTLE MARTIN

19a. Informant's Name/Relationship (Type, Print)

MARTHA G. HALL - WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

13840 BALLANTRAE LANE, WALDORF, MARYLAND 20601

20a. Method of Disposition

XX Burial 1 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

ST. PETER'S CHURCH CEM., DEC. 11, 1997, WALDORF, MD

Data

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

MARK G. BROHAWN

M00053

22. Name and Address of Facility

THE HONTI FUNERAL HOME, INC.
P.O. BOX 156, WALDORF, MARYLAND 20604

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

acute myocardial infarction

Approximate Interval Between Onset and Death

days

Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. arteriosclerotic cardiovascular disease

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D18545

29d. Date signed (Month, Day, Year)

DECEMBER 8, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PHILIP WISOTSKY, 700 OLD LINE CENTRE, #207, WALDORF, MARYLAND 20602

31. Date filed (Month, Day, Year)

DEC 12 1997

32. Registrar's Signature

John D. ...

State
Registrar

Baltimore, Maryland 21215-0020

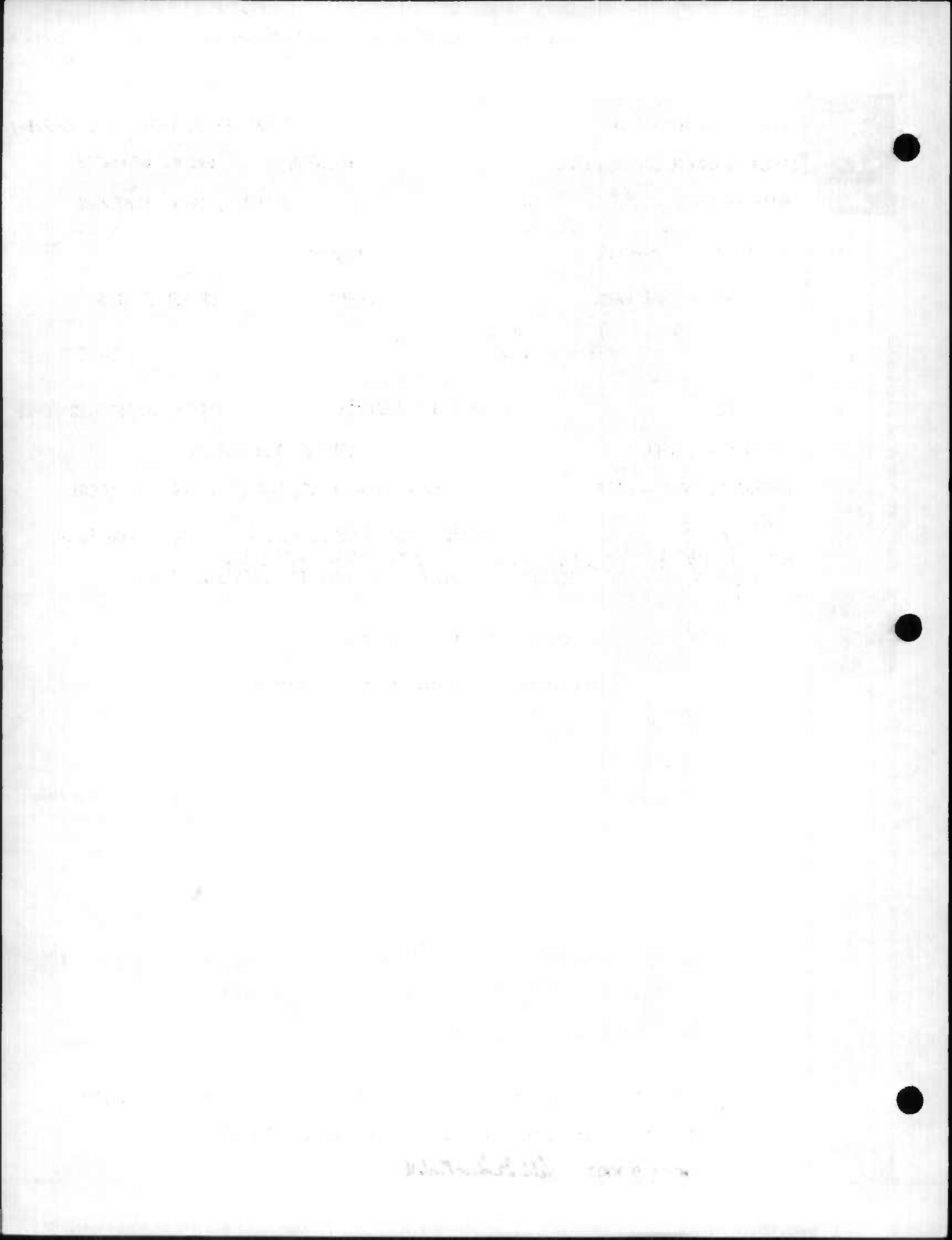
permits. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 38836

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|--|--|---|--|--|---|---|--|
| Physician /Medical Examiner | 1. Decedant's Name (First, Middle, Last) James Davis Head | | | | 2. Date of Death Month December Day 4 Year 1997 | | 3. Time of Death 3:00P. | |
| | 4a. Facility Name (If not institution, give street and number) 4911 Harford Avenue | | | | 4b. City, Town, or Location of Death Beltsville | | 4c. County of Death Prince George's | |
| Funeral Director | 5. Social Security Number 378-42-3958 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 55 Yrs. | | 8. Date of Birth (Month, Day, Year) Oct. 28, 1942 | |
| | 9. Birthplace (State or Foreign Country) Illinois | | 10a. State Maryland | | 10b. County Prince George's | | 10c. City, Town or Location Beltsville | |
| To Be Completed by Funeral Director | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number 4911 Harford Avenue | | 10f. Zip Code 20705 | | 10g. Citizen of What Country? United States | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedant Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedant of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| | 15. Decedant's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 Collage (1-4 or 5+) 4 | | 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Musician | | 16b. Kind of Business/Industry self employed | | | |
| | 17. Father's Name (First, Middle, Last) James Davis Head, Sr. | | | | 18. Mother's Name (First, Middle, Maiden Surname) Gladys Williams | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Cynthia A. Head (wife) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4911 Harford Avenue Beltsville, Maryland 20705 | | | |
| | 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory | | 20c. Location - City or Town, State 12/5/1997 Alexandria, Virginia | | 20d. Date | |
| | 21. Signature of Funeral Service Licensed Donald V. Borgwardt | | 22. Name and Address of Facility Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Road Beltsville, Maryland 20705 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. ACUTE LYMPHOCYTIC LEUKEMIA Due to (or as a consequence of): | | | | | | | |
| | 23b. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Due to (or as a consequence of): | | | | | | | |
| | 23c. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Due to (or as a consequence of): | | | | | | | |
| 23d. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Due to (or as a consequence of): | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 28d. Describe how Injury occurred | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| 29b. Signature and title of certifier Stephen Staal | | | | 29c. License number D18219 | | 29d. Date signed (Month, Day, Year) December 5, 1997 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stephen Staal, M.D. 1221 Mercantile Lane Largo, Maryland 20706 | | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 08 1997 | | | | 32. Registrar's Signature Johanna Davidson-Randall | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Walter D. Bond

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 38837

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Kathryn Elisabeth Heoney

2. Date of Death

Month Day Year
December 7, 1997

3. Time of Death

1120 AM

4a. Facility Name (If not institution, give street and number)

SHADY GROVE ADVENTIST HOSPITAL

4b. City, Town, or Location of Death

ROCKVILLE

4c. County of Death

MONTGOMERY

5. Social Security Number

203-09-9191

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

78 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Aug. 16, 1919

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Rockville

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

509 Mannakee Street

10f. Zip Code

20850

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
10

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Lawrence O'Hay

18. Mother's Name (First, Middle, Maiden Surname)

Catherine Clark

19a. Informant's Name/Relationship (Type, Print)

Rosalind Ann Bauer/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

509 Mannakee Street, Rockville, Maryland 20850

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Dec. 11, 1997
St. Mary's Cemetery

Date

20c. Location - City or Town, State

Rockville, Maryland

21. Signature of Funeral Service Licensee

Randy J. J...

M00198

22. Name and Address of Facility

Robert A. Pumphrey Funeral Home/Rockville, Inc.
300 West Montgomery Avenue
Rockville, Maryland 20850-2805

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. *CARDIOMYOPATHY*
Due to (or as a consequence of)b. *ISCHEMIC HEART DISEASE*
Due to (or as a consequence of):c.
Due to (or as a consequence of):d.
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 YR

10 YRS

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

*DIABETES MELITUS**HYPERTENSION*

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature] M.D.

29c. License number

D20674

29d. Date signed (Month, Day, Year)

December 7, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Stephen Hellman 6140 Mountrose Rd Rockville Md 20852

31. Date filed (Month, Day, Year)

DEC 10 1997

32. Registrar's Signature

*[Signature]*State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

1. The first part of the report is a general description of the project and its objectives. This section should provide a clear and concise overview of the work that has been done and the results that have been achieved.

2. The second part of the report is a detailed description of the methods used in the study. This section should provide a clear and concise overview of the procedures that were followed and the results that were obtained.

3. The third part of the report is a discussion of the results of the study. This section should provide a clear and concise overview of the findings and the conclusions that were drawn from the data.

4. The fourth part of the report is a conclusion and a summary of the findings. This section should provide a clear and concise overview of the results and the conclusions that were drawn from the data.

5. The fifth part of the report is a list of references. This section should provide a clear and concise overview of the sources that were used in the study.

6. The sixth part of the report is a list of appendices. This section should provide a clear and concise overview of the additional information that is provided in the report.

7. The seventh part of the report is a list of figures. This section should provide a clear and concise overview of the visual information that is provided in the report.

8. The eighth part of the report is a list of tables. This section should provide a clear and concise overview of the tabular information that is provided in the report.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38838

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Olive M. Holtje

2. Date of Death

Month Day Year
November 30, 1997

3. Time of Death

12:45 PM

4a. Facility Name (If not institution, give street and number)

Carriage Hill-Bethesda

4b. City, Town, or Location of Death

Bethesda

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

137-16-0353

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

80 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Dec. 4, 1916

9. Birthplace (State or Foreign Country)

New Jersey

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Kensington

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

10120 Cedar Lane

10f. Zip Code

20895

10g. Citizen of What Country?

United States

11. Marital Status

☐ Never Married ☐ Married
☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
☐ Yes ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No -
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Charles Vogel

18. Mother's Name (First, Middle, Maiden Surname)

Mary Denninger

19a. Informant's Name/Relationship (Type, Print)

Nelson Charles Holtje/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4107 Water View Drive, Edgewater, MD 21037

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)December 7, 1997
Montgomery Crematorium, Inc.

Data

20c. Location - City or Town, State

Bethesda, Maryland

21. Signature of Funeral Service Licensee

M00198

22. Name and Address of Facility

Robert A. Pumphrey Funeral Home/
7557 Wisconsin Avenue
Bethesda, Maryland 20814-3501Bethesda-Chevy
Chase, Inc.23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.

Carcinoma of the Colon

Approximate
Interval Between
Onset and Death

7 Years

Immediate Cause (Final
disease or condition
resulting in death)

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Duodenal Ulcer

Gastrointestinal Hemorrhage

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown24a. Was an autopsy
performed?☐ Yes ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?☐ Yes ☒ No25. Was case referred to medical
examiner?☐ Yes ☒ No

28. Place of Death (Check only one)

Hospital:

☐ Inpatient☐ ER/Outpatient☐ DOA

Other:

☒ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending
investigation
☐ Accident ☐ Could not be
determined
☐ Suicide ☐
☐ Homicide28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury28c. Injury at
Work?☐ Yes ☒ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

29c. License number

D09577

29d. Date signed (Month, Day, Year)

December 1, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Richard H. Pollen, M.D. 10400 Connecticut Avenue, Kensington, Maryland 20895

31. Date filed (Month, Day, Year)

DEC 10 1997

32. Registrar's Signature

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar


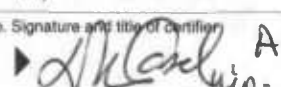
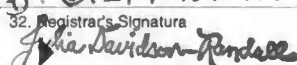
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38839

| | | | | | | | | |
|--|--|--|---|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) BETTY K. HOWARD | | | | 2. Date of Death Month Day Year DEC. 4, 1997 | | 3. Time of Death 3:15 PM | |
| | 4a. Facility Name (If not institution, give street and number) HEBREW HOME | | | | 4b. City, Town, or Location of Death ROCKVILLE | | 4c. County of Death MONTGOMERY | |
| Funeral Director | 5. Social Security Number 118-20-6242 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 103 Yrs. | | 8. Date of Birth (Month, Day, Year) AUG. 29, 1894 | |
| | 9. Birthplace (State or Foreign Country) NEW YORK | | 10a. State MD. | | 10b. County MONTGOMERY | | 10c. City, Town or Location ROCKVILLE | |
| To Be Completed by Funeral Director | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number 6121 MONTROSE RD. | | 10f. Zip Code 20852 | | 10g. Citizen of What Country? U.S.A. | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 Collega (1-4or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) SECRETARY | | 16b. Kind of Business/Industry SECRETARIAL | | | |
| | 17. Father's Name (First, Middle, Last) JOHN KING | | | | 18. Mother's Name (First, Middle, Maiden Surname) HANNAH UNKNOWN | | | |
| | 19a. Informant's Name/Relationship (Type, Print) HELEN CORNING/NIECE | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8340 NORTH BROOK LA., BETHESDA, MD. 20814 | | | |
| | 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) CHAMBERS CREMATORY | | Date 12/6/97 | | 20c. Location - City or Town, State RIVERDALE, MD. | |
| | 21. Signature of Funeral Service Licensee  W.W. Chambers M00091 | | | | 22. Name and Address of Facility CHAMBERS FUNERAL HOMES, P.A., SILVER SPRING, MD. 20910 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. ACUTE MYOCARDIAL INFARCTION Due to (or as a consequence of): b. CORONARY ARTERY DISEASE Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | |
| | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| Physician /Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. MULTI-INFARCT DEMENTIA | | | | | | | |
| | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | |
| | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury et Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28b. Location (Street and Number or Rural Route Number, City or Town, State) | | 28c. Location (Street and Number or Rural Route Number, City or Town, State) | | 28d. Location (Street and Number or Rural Route Number, City or Town, State) | |
| | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| | 29b. Signature and title of certifier  Attending Physician | | 29c. License number D18084 | | 29d. Date signed (Month, Day, Year) DECEMBER 05, 1997 | | | |
| State Registrar | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) D.D. PATEL MD. 6121 MONTROSE RD, ROCKVILLE, MD 20852 | | | | | | | |
| | 31. Date filed (Month, Day, Year) DEC 08 1997 | | 32. Registrar's Signature  | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "Natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38840

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Chaffie Warner Hinzman

2. Date of Death

Month Day Year
December 7, 1997

3. Time of Death

10:00P.

4a. Facility Name (If not institution, give street and number)

13Q Hillside Road

4b. City, Town, or Location of Death

Greenbelt

4c. County of Death

Prince George's

Funeral
Director

5. Social Security Number

235-60-6690

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

95 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year
April 2, 1902

9. Birthplace (State or Foreign Country)

West Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Greenbelt

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

13 Q Hillside Road

10f. Zip Code

20770

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

own home

17. Father's Name (First, Middle, Last)

Jarrett L. Warner

18. Mother's Name (First, Middle, Maiden Surname)

Margaret Jane Wilson

19a. Informant's Name/Relationship (Type, Print)

Maxine V. Smith (daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

same as #10

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Fairview Cemetery 12/13/1997

Date

20c. Location - City or Town, State

Weston, West Virginia

21. Signature of Funeral Service Licensee

Donald V. Borgwardt

22. Name and Address of Facility

Donald V. Borgwardt Funeral Home, P.A.
4400 Powder Mill Road Beltsville, Maryland 20705

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

Due to (or as a consequence of):

Renal Failure

Approximate Interval Between Onset and Death

yrs.

b.

Due to (or as a consequence of):

Arteriosclerosis

yrs.

c.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

d.

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Congestive Heart Failure
Asthma

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

David S. Schachter

29c. License number

H 15939

29d. Date signed (Month, Day, Year)

December 8, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

David S. Schachter, M.D. 7525 Greenway Center Dr., #212 Greenbelt, Maryland 20770

31. Date filed (Month, Day, Year)

DEC 8 1997

32. Registrar's Signature

John Anderson-Rodriguez

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38841

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ELMER AUGUSTA

HORMAN, JR.

2. Date of Death

Month Day Year
DECEMBER 7, 1997

3. Time of Death

2:42 P

4a. Facility Name (If not institution, give street and number)

SHADY GROVE ADVENTIST HOSPITAL

4b. City, Town, or Location of Death

ROCKVILLE

4c. County of Death

MONTGOMERY

Funeral
Director

5. Social Security Number

220 14 4879

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

74

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year
JUNE 30, 1923

9. Birthplace (State or Foreign)

MARYLAND

Usual Residence of Decedent

10a. State

MD.

10b. County

MONTGOMERY

10c. City, Town or Location

GAITHERSBURG

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

7 CHESTNUT STREET #7

10f. Zip Code

20877

10g. Citizen of What Country?

UNITED STATES

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever In U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,
Black, White, etc.

Specify: WHITE

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

10

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

ANIMAL CARETAKER

16b. Kind of Business/Industry

U. S. GOVERNMENT

17. Father's Name (First, Middle, Last)

ELMER A. HORMAN, SR.

18. Mother's Name (First, Middle, Maiden Summa)

MILDRED PRICE

19a. Informant's Name/Relationship (Type, Print)

HELEN M. HORMAN, WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7 CHESTNUT STREET, #7, GAITHERSBURG, MD. 20877

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of
cemetery, crematory or other place)

METROPOLITAN CREMATORY

Date

12/8/97

20c. Location - City or Town, State

ALEXANDRIA, VIRGINIA

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

MURIEL H. BARBER FUNERAL HOME
P.O. BOX 5038, LAYTONSVILLE, MD. 20882

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.

Immediate Cause (Final
disease or condition
resulting in death)

a. RESPIRATORY FAILURE

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

1 WK

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. CHRONIC OBSTRUCTIVE PULMONARY DISEASE

Due to (or as a consequence of):

40 YRS

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DEPRESSION, GRAV COMA, HYPERTENSION

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy
performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings
available prior to
completion of cause
of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical
examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient

2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury
(Month, Day Year)

28b. Time of
Injury

M

28c. Injury at
Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number,
City or Town, State)

29a. Certifier
(Check only
one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

[Signature] - MD

29c. License number

D36252

29d. Date signed (Month, Day, Year)

DEC. 08, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

STEVEN T. KARIYA, MD, 16220 FREDERICK RD #213, GAITHERSBURG MD 20877

31. Date filed (Month, Day, Year)

DEC 09 1997

32. Registrar's Signature

[Signature]

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23a-4 show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

THE UNIVERSITY OF CHICAGO PRESS

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38842

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

AGNES F. HUDSON

2. Date of Death

DEC 4 1997

3. Time of Death

1:48 PM

4a. Facility Name (If not institution, give street and number)

MONTGOMERY GENERAL HOSPITAL

4b. City, Town, or Location of Death

OLNEY

4c. County of Death

MONTGOMERY

Funeral
Director

5. Social Security Number

579-44-0327

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

82

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

MAY 11, 1915

9. Birthplace (State or Foreign Country)

WASH. D.C.

Usual Residence of Decedent

10a. State

MD.

10b. County

MONTGOMERY

10c. City, Town or Location

SILVER SPRING

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

15115 INTERLACHEN DR. #1021

10f. Zip Code

20906

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

EDUCATOR

16b. Kind of Business/Industry

EDUCATION

17. Father's Name (First, Middle, Last)

SIDNEY

FOGELGREN

18. Mother's Name (First, Middle, Maiden Surname)

VIOLA

UNKNOWN

19a. Informant's Name/Relationship (Type, Print)

WANDA P. DENNEY/FRIEND

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3598 FREMONT CT., IJAMSVILLE, MD. 21754

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

CHAMBERS CREMATORY

Date

12/6/97

20c. Location - City or Town, State

RIVERDALE, MD.

21. Signature of Funeral Service Licensee

W. Chambers

22. Name and Address of Facility

M00091 CHAMBERS FUNERAL HOMES, P.A., SILVER SPRING, MD. 20910

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CLINICAL CVA

Due to (or as a consequence of):

b. PROGRESSIVE MULTIINFARCT DEMENTIA

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Acute

7 YEARS

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☒ ER/Outpatient

3 ☐ DOA

Other:

4 ☐ Nursing Home

5 ☐ Residence

6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Thomas E. Dooley, MD

29c. License number

016458

29d. Date signed (Month, Day, Year)

Dec 4, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

THOMAS E. DOOLEY, MD 17904 GEORGIA AVENUE OLNEY, MD.

31. Date filed (Month, Day, Year)

DEC 08 1997

32. Registrar's Signature

Julia Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38843

| | | | | | | | | |
|--|--|--|---------------------------------|---|--|---|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) FRED INGRAM | | | | 2. Date of Death Month November Day 30 Year 1997 | | 3. Time of Death 11:33 PM | |
| | 4a. Facility Name (If not institution, give street and number) Holy Cross Hospital | | | | 4b. City, Town, or Location of Death Silver Springs, Md | | 4c. County of Death Montgomery County | |
| Funeral Director | 5. Social Security Number 246-13-6009 | | 6. Sex 1 M 2 F | | 7. Age (In yrs. last birthday) 34 Yrs. | | 8. Date of Birth (Month, Day, Year) August 15, 1963 | |
| | 9. Birthplace (State or Foreign Country) Scotland County, N.C. | | 10a. State Florida | | 10b. County Broward County | | 10c. City, Town or Location Ft. Lauderdale | |
| 10d. Inside City Limits 1 Yes 2 No | | 10e. Street and Number 708 South West 13th Ave | | 10f. Zip Code 33312 | | 10g. Citizen of What Country? U.S.A. | | |
| 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No) 1 Yes 2 No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: BLACK | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) waiter | | 16b. Kind of Business/Industry Restaurant | | | | |
| 17. Father's Name (First, Middle, Last) Fred Ingram | | | | 18. Mother's Name (First, Middle, Maiden Surname) YVONNE MCCOY | | | | |
| 19a. Informant's Name/Relationship (Type, Print) BRIAN INGRAM | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 440 PERMITA COURT ANNISTON, AL. 36206 | | | | |
| 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Ellerbe Grove Baptist Church Cemetery | | 20c. Location - City or Town, State Hamlet, N.C. 28345 | | 20d. Date 12-7-97 | | |
| 21. Signature of Funeral Service Licensee W.H. KNOTT FSL 1142 | | | | 22. Name and Address of Facility Nelson Funeral Service 511 Rockingham Rd. Rockingham, N.C. 28379 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Respiratory Failure Due to (or as a consequence of): b. Cryptococcal meningitis Due to (or as a consequence of): c. Acquired Immune Deficiency Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | |
| Approximate Interval Between Onset and Death Hours Days Years | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown | | |
| | | | | | | 24a. Was an autopsy performed? 1 Yes 2 No | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No | | |
| 25. Was case referred to medical examiner? 1 Yes 2 No | | Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA | | 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) | | | | |
| 27. Manner of Death 1 Natural 5 Pending Investigation 2 Accident 6 Could not be determined 3 Suicide 4 Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 Yes 2 No | | |
| | | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28d. Describe how injury occurred | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier | | 29c. License number D20678 | | 29d. Date signed (Month, Day, Year) Dec 1, 1997 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EDWARDA M. BUDA MD 3904 Cleveland St Kensington MD 20895 | | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 11 1997 | | 32. Registrar's Signature | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "Natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified in writing.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38844

| | | | | | | | | | | |
|---|---|---|--|--------------------------|--|---|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Paul Itsuo Ishimoto | | | | 2. Date of Death Month Day Year December 10, 1997 | | | | 3. Time of Death 2:30 AM | |
| | 4e. Facility Name (If not institution, give street and number) Carriage Hill - Bethesda | | | | 4b. City, Town, or Location of Death Bethesda | | | | 4c. County of Death Montgomery | |
| Funeral Director | 5. Social Security Number 216-38-5959 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 83 Yrs. | | If Under 1 Year Months Days | | If Under 24 Hrs. Hours Min. | |
| | 8. Date of Birth (Month, Day, Year) September 16, 1914 | | 9. Birthplace (State or Foreign Country) Hawaii | | 10a. State Maryland | | 10b. County Montgomery | | 10c. City, Town or Location Chevy Chase | |
| To Be Completed by Funeral Director | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number 8101 Connecticut Avenue, Unit C304 | | 10f. Zip Code 20815 | | 10g. Citizen of What Country? United States | | | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Japanese | | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 2 | | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Translator | | 16b. Kind of Business/Industry Department of Commerce | | | | | |
| | 17. Father's Name (First, Middle, Last) Fusakichi Ishimoto | | | | 18. Mother's Name (First, Middle, Maiden Surname) Shizuyo Ishida | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print) May Ishimoto (wife) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8101 Connecticut Avenue, #C304, Chevy Chase, MD 20815 | | | | | |
| | 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Chesapeake Crematory | | Date 12-10-97 | | 20c. Location - City or Town, State Beltsville, Maryland | | | |
| | 21. Signature of Funeral Service Licensee E. L. Villalba | | | | 22. Name and Address of Facility Rapp Funeral Services, P.A. 933 Gist Avenue, Silver Spring, Maryland 20910 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Cerebrovascular Accident Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | | | | | | | Approximate interval between Onset and Death 8 Hours | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Parkinson's Disease Coronary Artery Disease Dementia | | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier Wesley B. Mason M.D. | | | | 29c. License number D 22235 | | 29d. Date signed (Month, Day, Year) December 10, 1997 | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Wesley B. Mason, M.D., 10810 Connecticut Avenue, Kensington, Maryland 20895 | | 31. Date filed (Month, Day, Year) DEC 11 1997 | | | | | | | | |
| 32. Registrar's Signature Julia Davidson-Randall | | | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.




Medical Certification: To Be Completed by Physician/Medical Examiner

Physician
/Medical
Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

Reg. No.

38845

| | | | | | | | | | | |
|--|---|----------------------------------|---|--|---|--|--|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Edith Evans Jones | | | | | 2. Date of Death Month December Day 06 Year 1997 | | 3. Time of Death 1834 | | |
| | 4a. Facility Name (If not institution, give street and number) SHADY GROVE ADVENTIST HOSPITAL | | | | | 4b. City, Town, or Location of Death ROCKVILLE | | 4c. County of Death MONTGOMERY | | |
| Funeral Director | 5. Social Security Number 100-26-3023 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 87 Yrs. | | 8. Date of Birth (Month, Day, Year) July 30, 1910 | | 9. Birthplace (State or Foreign Country) New Jersey | |
| | Usual Residence of Decedent | | | | | | | | | |
| 10a. State Maryland | | 10b. County Montgomery | | 10c. City, Town or Location Gaithersburg | | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 10e. Street and Number 773 Quince Orchard Boulevard, Apt. 13 | | | | | 10f. Zip Code 20878 | | 10g. Citizen of What Country? United States | | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: Black | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4or 5+) 4 | | | | | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Social Worker | | | 16b. Kind of Business/Industry Adoption Agency | | |
| 17. Father's Name (First, Middle, Last) Lemuel Evans | | | | | 18. Mother's Name (First, Middle, Maiden Surname) Alice Folkes | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Charles F. Jones (husband) | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 773 Quince Orchard Boulevard, Apt. 13, Gaithersburg, MD 20878 | | | | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Chesapeake Crematory | | Date 12-9-97 | | 20c. Location - City or Town, State Beltsville, Maryland | | | |
| 21. Signature of Funeral Service Licensee  | | | | | 22. Name and Address of Facility Rapp Funeral Services, P.A. 933 Gist Avenue, Silver Spring, Maryland 20910 | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <div style="display: flex; justify-content: space-between;"> <div style="width: 30%;"> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last</p> </div> <div style="width: 65%;"> <p>a. Atherosclerotic coronary vascular disease Due to (or as a consequence of):</p> <p>b. Hypertension Due to (or as a consequence of):</p> <p>c. Chronic Renal Failure Due to (or as a consequence of):</p> <p>d.</p> </div> </div> | | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | | | | | | |
| 23c. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Abdominal aortic aneurysm | | | | | | | | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | |
| 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | 29b. Signature and title of certifier  MD | | 29c. License number D46741 | | 29d. Date signed (Month, Day, Year) December 06, 1997 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Deepak Sachdeva 9901 Medical Center Drive Rockville, Maryland 20850 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 09 1997 | | | | | 32. Registrar's Signature  | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38846

| | | | | | | | | | | |
|---|---|---|---|--|---|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Harold Francis Jones, Jr. | | | | | | 2. Date of Death Month Day Year December 5, 1997 | | 3. Time of Death 1:05 PM | |
| | 4a. Facility Name (If not institution, give street and number) 691 Willowby Run | | | | | | 4b. City, Town, or Location of Death Pasadena | | 4c. County of Death Anne Arundel | |
| Funeral Director | 5. Social Security Number 229-18-5634 | | 6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 75 Yrs. | | 8. Date of Birth (Month, Day, Year) May 24, 1922 | | 9. Birthplace (State or Foreign Country) Washington, DC | |
| | Usual Residence of Decedent | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State MD | | 10b. County Anne Arundel | | 10c. City, Town or Location Pasadena | | | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| | 10e. Street and Number 691 Willowby Run | | | | 10f. Zip Code 21122 | | 10g. Citizen of What Country? USA | | | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 1942-45 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Collage (1-4or 5+) 4 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Manager | | | 16b. Kind of Business/Industry Federal Government | | |
| | 17. Father's Name (First, Middle, Last) Harold Francis Jones, Sr. | | | | | | 18. Mother's Name (First, Middle, Maiden Surname) Ellen Grace Cleary | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) Marilyn A. Barrett (daughter) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4790 Tapestry Drive, Fairfax, VA 22032 | | | | | |
| | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Gate of Heaven Cemetery | | Date 12/10/97 | | 20c. Location - City or Town, State Silver Spring, MD | | | |
| | 21. Signature of Funeral Service Licensee <i>Eric S. Smith</i> | | | | 22. Name and Address of Facility Francis J. Collins Funeral Home, Inc. 500 University Blvd. West Silver Spring, MD 20901 | | | | | |
| | 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. <i>Gangrene foot</i> Due to (or as a consequence of): b. <i>atherosclerosis diffuse</i> Due to (or as a consequence of): c. <i>Diabetes</i> Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | | | | | | |
| | Approximate Interval Between Onset and Death <i>One month</i> <i>years</i> <i>11 years</i> | | | | | | | | | |
| Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020 | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>severe osteoporosis</i> <i>Aortic Aneurysm</i> <i>Dementia</i> | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | |
| | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | |
| | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| State Registrar | 29a. Certifier (Check only one) 2 <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| | 29b. Signature and title of certifier <i>[Signature]</i> | | | | 29c. License number D31998 | | 29d. Date signed (Month, Day, Year) 12-9-97 | | | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michelle SMADDA-GORON 205 Ridgely Ave Ann Arundel MD 21401 | | | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 10 1997 | | 32. Registrar's Signature <i>[Signature]</i> | | | | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

97 38847

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last) **Sherman I. Jones** 2. Date of Death Month **December** Day **09** Year **1997** 3. Time of Death **1620**

Funeral
Director

4a. Facility Name (If not institution, give street and number) **SHADY GROVE ADVENTIST HOSPITAL** 4b. City, Town, or Location of Death **ROCKVILLE** 4c. County of Death **MONTGOMERY**

5. Social Security Number **028-24-6639** 6. Sex ☒ M ☐ F 7. Age (In yrs. last birthday) **65** Yrs. 8. Date of Birth (Month, Day, Year) **Nov. 4, 1932** 9. Birthplace (State or Foreign Country) **Maine**

Usual Residence of Decedent 10a. State **Maryland** 10b. County **Montgomery** 10c. City, Town or Location **Rockville** 10d. Inside City Limits ☒ Yes ☐ No

10e. Street and Number **613 West Lynfield Drive** 10f. Zip Code **20850** 10g. Citizen of What Country? **United States**

11. Marital Status ☐ Never Married ☒ Married ☐ Widowed ☐ Divorced 12. Was Decedent Ever in U.S. Armed Forces? ☒ Yes ☐ No If Yes, Give Year or Dates **Korea Vietnam** 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ☐ Yes ☒ No Specify: 14. Race - American Indian, Black, White, etc. Specify: **White**

15. Decedent's Education (Specify only highest grade completed) **Elementary/Secondary (0-12)** **12** **College (1-4 or 5+)** 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) **Engineer** 16b. Kind of Business/Industry **U.S. Government**

17. Father's Name (First, Middle, Last) **Irving Jones** 18. Mother's Name (First, Middle, Maiden Surname) **Matilda Jones**

19a. Informant's Name/Relationship (Type, Print) **Carolyn B. Jones/Wife** 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) **613 West Lynfield Drive, Rockville, MD 20850**

20a. Method of Disposition ☐ Burial ☒ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) **Dec. 12, 1997** **Montgomery Crematorium, Inc.** 20c. Location - City or Town, State **Bethesda, Maryland**

21. Signature of Funeral Service Licensee **Randy Jones** **M00198** 22. Name and Address of Facility **Robert A. Pumphrey Funeral Home/Rockville, Inc.** **300 West Montgomery Avenue** **Rockville, Maryland 20850-2805**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Acute Myocardial Infarction** **Severe Coronary Insufficiency** **Atherosclerotic Cardiovascular Disease** **15 minutes** **20 years** **30 years**

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. **Ruptured abdominal aortic aneurysm** **Chronic Obstructive Pulmonary Disease**

23b. Did tobacco use contribute to the cause of death? ☐ Yes ☐ No ☒ Probably ☐ Unknown 24a. Was an autopsy performed? ☐ Yes ☒ No 24b. Were autopsy findings available prior to completion of cause of death? ☐ Yes ☐ No

25. Was case referred to medical examiner? ☐ Yes ☒ No 26. Place of Death (Check only one) Hospital: ☒ Inpatient ☐ ER/Outpatient ☐ DOA Other: ☐ Nursing Home ☐ Residence ☐ Other (Specify) 27. Manner of Death ☒ Natural ☐ Accident ☐ Suicide ☐ Homicide ☐ Pending investigation ☐ Could not be determined 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury **M** 28c. Injury at Work? ☐ Yes ☒ No 28d. Describe how Injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier **Mario H. Diaz MD** 29c. License number **D22049** 29d. Date signed (Month, Day, Year) **December 09, 1997**

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) **MARIO DIAZ** **18111 Prince Phillip Drive Olney Maryland 20832**

31. Date filed (Month, Day, Year) **DEC 12 1997** 32. Registrar's Signature **J. Davidson**

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 38848

Amend #8, 12/8/97, BMW, Montg. Co

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| 1. Decedent's Name (First, Middle, Last) GENEVIEVE MARY KEY | | | | 2. Date of Death Month December Day 4 , Year 1997 | | 3. Time of Death 12¹⁰ PM | |
| 4a. Facility Name (If not institution, give street and number) Williamsport Retirement Village | | | | 4b. City, Town, or Location of Death Williamsport | | 4c. County of Death Washington | |
| 5. Social Security Number 219-05-2741 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 85 Yrs. | | 8. Date of Birth (Month, Day, Year) Mar. 15, 1911 | |
| 9. Birthplace (State or Foreign Country) Maryland | | 10a. State MD | | 10b. County Montgomery | | 10c. City, Town or Location Gaithersburg | |
| 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number 7925 Spiceberry Ct., #D | | 10f. Zip Code 20877 | | 10g. Citizen of What Country? U.S.A. | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Black | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Housewife | | 16b. Kind of Business/Industry Home | | 17. Father's Name (First, Middle, Last) Horace Johnson | |
| 18. Mother's Name (First, Middle, Maiden Surname) Lucy H. Brown | | 19a. Informant's Name/Relationship (Type, Print) Irene E. Plummer (Sister) | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7925 Spiceberry Ct., #A, Gaithersburg, MD 20877 | | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | |
| 20b. Place of Disposition (Name of cemetery, crematory or other place) Parklawn Mem. Park | | 20c. Location - City or Town, State Rockville, MD | | 21. Signature of Funeral Service Licensee <i>George R. Brondsen</i> | | 22. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A. ROCKVILLE, MD 20850 | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. PULMONARY EDEMA Due to (or as a consequence of): b. CONGESTIVE HEART FAILURE Due to (or as a consequence of): c. INSULIN DEPENDENT DIABETES MELLITUS Due to (or as a consequence of): d. | | Approximate Interval Between Onset and Death HOURS YEARS years | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | |
| 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier <i>Sandy Spring Staff Physician</i> | |
| 29c. License number D 4 2046 | | 29d. Date signed (Month, Day, Year) December 4, 1997 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GRACE BROOKE HUFFMAN, MD 18100 Slade School Road Sandy Spring Maryland 20860 | | 31. Date filed (Month, Day, Year) DEC 8 1997 | |
| 32. Registrar's Signature <i>John Davidson-Rodale</i> | | 33. State Registrar | | 34. Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020 | | 35. To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form. | |

To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

Physician
/Medical
Examiner

1. The first part of the report is a general
description of the project and its objectives.

2. The second part of the report is a detailed
description of the methodology used in the study.

3. The third part of the report is a detailed
description of the results of the study.

4. The fourth part of the report is a detailed
description of the conclusions of the study.

5. The fifth part of the report is a detailed
description of the recommendations of the study.

6. The sixth part of the report is a detailed
description of the limitations of the study.

7. The seventh part of the report is a detailed
description of the future work.

8. The eighth part of the report is a detailed
description of the references.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38849

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

SERUCH

TITUS

Kimble

2. Date of Death

Month

Day

Year

December 10, 1997

3. Time of Death

11:20 P.M.

4a. Facility Name (If not institution, give street and number)

Washington Adventist Hospital

4b. City, Town, or Location of Death

Takoma Park

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

577-24-7600

6. Sex

M ☒ F ☐

7. Age (In yrs. last birthday)

76 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Feb. 21, 1921

9. Birthplace (State or Foreign Country)

Washington, D.C.

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Olney

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3333 Emory Church Road

10f. Zip Code

20832

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Physician

16b. Kind of Business/Industry

Medicine

17. Father's Name (First, Middle, Last)

Seruch Titus Kimble, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Harriet Louise Zebley

19a. Informant's Name/Relationship (Type, Print)

Helen Kimble / Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3333 Emory Church Road, Olney, Maryland 20832

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Head of Christiana Cemetery 12/15/97 Newark, Delaware

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Shirley Caporatti

22. Name and Address of Facility

Hines-Rinaldi Funeral Home

11800 New Hampshire Avenue

Silver Spring, Maryland 20904

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. IDIOPATHIC PULMONARY FIBROSIS

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

10 YEARS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of injury

(Month, Day Year)

28b. Time of injury

M

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28a. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Joseph B. Mizgerd, M.D.

29c. License number

D08425

29d. Date signed (Month, Day, Year)

DECEMBER 10, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

JOSEPH B. MIZGERD, M.D.

7600 CARROLL AVE.

TAKOMA PARK, MD 20912

31. Date filed (Month, Day, Year)

DEC 12 1997

32. Registrar's Signature

Julia Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or items 23a or 26a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

15

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 38850

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|---|--|--|--|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Rafiq B. Khan | | | | 2. Date of Death Month December Day 8 Year 1997 | | 3. Time of Death 2:30 PM | |
| | 4e. Facility Name (If not institution, give street and number) Golden Oaks Nursing Home | | | | 4b. City, Town, or Location of Death Silver Spring | | 4c. County of Death Montgomery | |
| Funeral Director | 5. Social Security Number 215-90-6476 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 62 Yrs. | | 8. Date of Birth (Month, Day, Year) Dec. 2, 1935 | |
| | 9. Birthplace (State or Foreign Country) India | | 10a. State Maryland | | 10b. County Montgomery | | 10c. City, Town or Location Silver Spring | |
| 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number 12405 O'Fallon Street | | 10f. Zip Code 20904 | | 10g. Citizen of What Country? India | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Pakistani | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker | | 16b. Kind of Business/Industry Domestic | | 17. Father's Name (First, Middle, Last) Zia Hussain | | |
| 18. Mother's Name (First, Middle, Maiden Surname) Shagila Bano | | 19a. Informant's Name/Relationship (Type, Print) Sayedian Khan / Son | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 301 North Beauregard St., #1706, Alexandria, VA 22312 | | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | |
| 20b. Place of Disposition (Name of cemetery, crematory or other place) George Washington Cem. | | 20c. Date 12/9/97 | | 20d. Location - City or Town, State Adelphi, Maryland | | 21. Signature of Funeral Service Licensee | | |
| 22. Name and Address of Facility Hines-Rinaldi Funeral Home 11800 New Hampshire Avenue Silver Spring, Maryland 20904 | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Acute Pulmonary Embolism Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | Approximate Interval Between Onset and Death 20 minute | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | |
| 29b. Signature and title of certifier M.D. | | 29c. License number D 24721 | | 29d. Date signed (Month, Day, Year) 12/9/97 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SYED SADIQ 14800, 4th St. LAUREL, MD. 20707 | | |
| 31. Date filed (Month, Day, Year) DEC 10 1997 | | 32. Registrar's Signature | | 33. State Registrar | | 34. Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020 | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 38851

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ROSE

LAGUNOFF

2. Date of Death

Month Day Year
Dec. 2, 1997

3. Time of Death

2:25pm

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Springbrook Nursing Home

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

5. Social Security Number

105-24-8023

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

102

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Jan 1, 1895

9. Birthplace (State or Foreign Country)

Russia

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

12325 New Hampshire Ave.

10f. Zip Code

20904

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Designer/Housewife

16b. Kind of Business/Industry

Garment/ Own Home

17. Father's Name (First, Middle, Last)

Iosel Benderowski

18. Mother's Name (First, Middle, Maiden Surname)

Sheina-Asna (unknown)

19a. Informant's Name/Relationship (Type, Print)

Marsha L. Mittelman-Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

13113 Two Farm Drive Silver Spring, MD 20904

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Knollwood Park Cemetery

Date

12/5/97

20c. Location - City or Town, State

Ridgewood, NY

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

EDWARD SAGEL FUNERAL DIRECTION

1091 ROCKVILLE PIKE - ROCKVILLE, MARYLAND 20852

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

Due to (or as a consequence of):

Dehydration

b.

Due to (or as a consequence of):

Dehydration

c.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

d.

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

days

Years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

DECEMBER 3, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. MICHAEL LEIBOWITZ - 11120 NEW HAMPSHIRE AVENUE #305 - SILVER SPRING, MD. 20904

State
Registrar

31. Date filed (Month, Day, Year)

DEC 08 1997

32. Registrar's Signature

Johanna Davidson-Randall

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Marie E. Lanahan

2. Date of Death

Month Day Year
December 6, 1997

3. Time of Death

8:50 PM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Rockville Nursing Home

4b. City, Town, or Location of Death

Rockville

4c. County of Death

Montgomery

5. Social Security Number

579-62-9656

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

100 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Nov. 11, 1897

9. Birthplace (State or Foreign Country)

Washington, DC

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Rockville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

4707 Topping Road

10f. Zip Code

20852

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

10

College (1-4or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

William F. Barrett

18. Mother's Name (First, Middle, Maiden Surname)

Susan C. Kelly

19a. Informant's Name/Relationship (Type, Print)

Thomas B. Lanahan (son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4707 Topping Road, Rockville, MD 20852

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Gate of Heaven Cemetery 12/10/97 Silver Spring, MD

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

Francis J. Collins Funeral
Home, Inc. 500 University Blvd. West
Silver Spring, MD 2090123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a. ACUTE MYOCARDIAL INFARCTION

4 DAYS

Due to (or as a consequence of):

b. ARTERIOSCLEROTIC HEART DISEASE

30 YEARS

Due to (or as a consequence of):

c. GENERALIZED ARTERIOSCLEROSIS

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending

Investigation

6 ☐ Could not be

determined

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)
☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier



29c. License number

D-02047

29d. Date signed (Month, Day, Year)

Dec 8, 1997

30. Name and address of person who completed cause of death (item 23e) (Type, Print)

JOSEPH D. CONNOR, M.D. 6000 Executive Blvd. #300 Rockville, MD 20852

31. Date filed (Month, Day, Year)

DEC 10 1997

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

87 38853

| | | | | | | | | | | | | | | | | | | | | | |
|--|---|--|---|---|--|--|--|---|------------------------|---|----------------------------------|--|-------------------------------|---------------|----------------------------------|--|--|----|--|----|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) LEONARD L. LEDERMAN | | | | 2. Date of Death Month DEC. Day 9, Year 1997 | | 3. Time of Death 5:50PM | | | | | | | | | | | | | | |
| | 4a. Facility Name (If not institution, give street and number) SUBURBAN HOSPITAL | | | | 4b. City, Town, or Location of Death BETHESDA | | 4c. County of Death MONTGOMERY | | | | | | | | | | | | | | |
| Funeral Director | 5. Social Security Number 108-24-7489 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 66 Yrs. | | 8. Date of Birth (Month, Day, Year) NOV. 23, 1931 | | | | | | | | | | | | | | |
| | 9. Birthplace (State or Foreign Country) NY | | | | | | | | | | | | | | | | | | | | |
| To Be Completed by Funeral Director | Usual Residence of Decedent | | | | | | | | | | | | | | | | | | | | |
| | 10a. State MD | | 10b. County MONTGOMERY | | 10c. City, Town or Location BETHESDA | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | |
| | 10e. Street and Number 5602 RIDGEFIELD RD. | | | | 10f. Zip Code 20816 | | 10g. Citizen of What Country? USA | | | | | | | | | | | | | | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | | | | | | | | | | | | | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (14 or 5+) <input checked="" type="checkbox"/> 5+ | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) ECONOMIST | | 16b. Kind of Business/Industry NATIONAL SCIENCE FOUND. | | | | | | | | | | | | | | | | |
| | 17. Father's Name (First, Middle, Last) HYMAN LEDERMAN | | | | 18. Mother's Name (First, Middle, Maiden Surname) YETTA DREYFUS | | | | | | | | | | | | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print) FLORENCE LEDERMAN / WIFE | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5602 RIDGEFIELD RD., BETHESDA, MD 20816 | | | | | | | | | | | | | | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) KING DAVID MEMORIAL GARD. | | 20c. Date 12/12/97 | | 20d. Location - City or Town, State FALLS CHURCH, VA | | | | | | | | | | | | | | |
| | 21. Signature of Funeral Service Licensee  DANIEL SIMONS | | | | 22. Name and Address of Facility EDWARD SAGEL FUNERAL DIRECTION, INC. 1091 ROCKVILLE PIKE, ROCKVILLE, MD 20852 | | | | | | | | | | | | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | | | | | | | | | |
| <table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a. SEPTIC SHOCK</td> <td>Approximate Interval Between Onset and Death 1 WEEK</td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> </tr> <tr> <td>b. STAPHYLOCCAL SEPSIS</td> <td>1 WEEK</td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> </tr> <tr> <td rowspan="2">Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last</td> <td>c.</td> <td></td> </tr> <tr> <td>d.</td> <td></td> </tr> </table> | | | | | | | | Immediate Cause (Final disease or condition resulting in death) | a. SEPTIC SHOCK | Approximate Interval Between Onset and Death 1 WEEK | Due to (or as a consequence of): | | b. STAPHYLOCCAL SEPSIS | 1 WEEK | Due to (or as a consequence of): | | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | c. | | d. | |
| Immediate Cause (Final disease or condition resulting in death) | a. SEPTIC SHOCK | Approximate Interval Between Onset and Death 1 WEEK | | | | | | | | | | | | | | | | | | | |
| | Due to (or as a consequence of): | | | | | | | | | | | | | | | | | | | | |
| | b. STAPHYLOCCAL SEPSIS | 1 WEEK | | | | | | | | | | | | | | | | | | | |
| | Due to (or as a consequence of): | | | | | | | | | | | | | | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | c. | | | | | | | | | | | | | | | | | | | | |
| | d. | | | | | | | | | | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | | | | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | | | | | | | | | | | | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | | | | | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | | |
| 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | | | | | | | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | | | | | | | |
| | | 28d. Describe how Injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | | | | | | | | | | | | |
| 29b. Signature and title of certifier  Daniel Rosenthal MD | | | | 29c. License number 204766 | | 29d. Date signed (Month, Day, Year) 12-10-97 | | | | | | | | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DANIEL ROSENBLUM, MD | | | | 10400 CONNECTICUT AVE 602 KENSINGTON, MD 20895 | | | | | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 12 1997 | | 32. Registrar's Signature  | | | | | | | | | | | | | | | | | | | |

7:19 PM
Nils A. Lofgren December 07, 1997
Baltimore, Maryland 21215-0020
Division of Vital Records, P.O. Box 68760,
Baltimore, Maryland 21215-0020
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38854

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Nils Adolph Lofgren

2. Date of Death

Month Day Year
December 7, 1997

3. Time of Death

7:19 PM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Charlotte Hall Veterans Home

4b. City, Town, or Location of Death

Charlotte Hall

4c. County of Death

St. Marys

5. Social Security Number

541-12-1903

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

76

8. Date of Birth

Month Day Year

Oct. 16, 1921

9. Birthplace (State or Foreign Country)

Sweden

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Rockville

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

12236 Tildenwood Drive

10f. Zip Code

20852

10g. Citizen of What Country?

United States

11. Marital Status

☐ Never Married ☒ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☒ Yes ☐ No World War II

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

3

16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Traffic Safety Consultant

16b. Kind of Business/Industry

Motor Vehicle

Manufacturer's Assn.

17. Father's Name (First, Middle, Last)

Hilmer Lofgren

18. Mother's Name (First, Middle, Maiden Surname)

Frieda Larson

19a. Informant's Name/Relationship (Type, Print)

Josephine A. Lofgren/ Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12236 Tildenwood Drive, Rockville, Maryland 20852

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Dec. 10, 1997
Montgomery Crematorium, Inc.

Data

20c. Location - City or Town, State

Bethesda, Maryland

21. Signature of Funeral Service Licensee

[Signature]

M00689

22. Name and Address of Facility Robert A. Pumphrey Funeral Home/
Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue,
Bethesda, Maryland 20814-3501

23. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. MALNUTRITION

FEW DAYS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. ADVANCED ALZHEIMER DISEASE YRS

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☐ Probably ☒ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital: ☐ Inpatient ☐ ER/Outpatient ☐ DOA

Other: ☒ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending Investigation
☐ Accident ☐ Could not be determined
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? ☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

[Signature]

29c. License number

D-44436

29d. Date signed (Month, Day, Year)

DEC. 08 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

ASHVINKUMAR J PATEL 603 Post Office Rd # 207
WALDORF MD 20602

State
Registrar

31. Date filed (Month, Day, Year)

DEC 10 1997

32. Registrar's Signature

[Signature]

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

Reg. No.

97 38855

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|--|---|---|---|--|--|---|--|---|--|--|---|---|---|---|---|----------------------------------|----|--|----------------------------------|--|---------------------------------------|---|--|-----------------------------------|----------------------------------|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) DENNES ALLEN MILLS, SR. | | | | 2. Date of Death Month DECEMBER Day 6 Year 1997 | | | | 3. Time of Death 1:33AM | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 4e. Facility Name (If not institution, give street and number) 5010 DORCHESTER CIRCLE | | | | 4b. City, Town, or Location of Death WALDORF | | | | 4c. County of Death CHARLES | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Funeral Director | 5. Social Security Number 219-80-0420 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 38 Yrs. | | 8. Date of Birth (Month, Day, Year) JUNE 28, 1959 | | 9. Birthplace (State or Foreign Country) WASHINGTON DC | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | Usual Residence of Decedent | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 10a. State MARYLAND | | | 10b. County CHARLES | | 10c. City, Town or Location WALDORF | | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 10e. Street and Number 5010 DORCHESTER CIRCLE | | | | | 10f. Zip Code 20603 | | | 10g. Citizen of What Country? UNITED STATES | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0 | | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) TRUCK DRIVER | | | | 16b. Kind of Business/Industry GIANT FOOD | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 17. Father's Name (First, Middle, Last) CHARLES NEWTON MILLS, JR. | | | | | | 18. Mother's Name (First, Middle, Maiden Surname) ANN MARIE JENNINGS | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) SUSAN L. MILLS - WIFE | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5010 DORCHESTER CIRCLE, WALDORF, MARYLAND 20603 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) TRINITY MEM. GARDENS | | | | 20c. Location - City or Town, State DECEMBER 10, 1997 WALDORF, MD | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21. Signature of Funeral Service Licensee MGB Mark G. Brohawn | | | | 22. Name and Address of Facility THE HUNT FUNERAL HOME, INC. P.O. BOX 156, WALDORF, MARYLAND 20604 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <table border="0" style="width:100%;"> <tr> <td style="width:30%; vertical-align: top;"> Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last </td> <td style="width:70%; vertical-align: top;"> <table border="0"> <tr> <td style="width:5%; text-align: center;">a.</td> <td>CANCER OF HEAD AND NECK</td> <td rowspan="4" style="width:5%; text-align: center; vertical-align: middle; font-size: 4em;">{</td> <td style="width:10%; text-align: center;">Due to (or as a consequence of):</td> </tr> <tr> <td>b.</td> <td></td> <td style="text-align: center;">Due to (or as a consequence of):</td> </tr> <tr> <td>c.</td> <td></td> <td style="text-align: center;">Due to (or as a consequence of):</td> </tr> <tr> <td>d.</td> <td></td> <td style="text-align: center;">Due to (or as a consequence of):</td> </tr> </table> </td> </tr> </table> | | | | | | | | | | | Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | <table border="0"> <tr> <td style="width:5%; text-align: center;">a.</td> <td>CANCER OF HEAD AND NECK</td> <td rowspan="4" style="width:5%; text-align: center; vertical-align: middle; font-size: 4em;">{</td> <td style="width:10%; text-align: center;">Due to (or as a consequence of):</td> </tr> <tr> <td>b.</td> <td></td> <td style="text-align: center;">Due to (or as a consequence of):</td> </tr> <tr> <td>c.</td> <td></td> <td style="text-align: center;">Due to (or as a consequence of):</td> </tr> <tr> <td>d.</td> <td></td> <td style="text-align: center;">Due to (or as a consequence of):</td> </tr> </table> | a. | CANCER OF HEAD AND NECK | { | Due to (or as a consequence of): | b. | | Due to (or as a consequence of): | c. | | Due to (or as a consequence of): | d. | | Due to (or as a consequence of): | | | | | | | | | | | | | | | | |
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| a. | CANCER OF HEAD AND NECK | { | Due to (or as a consequence of): | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| b. | | | Due to (or as a consequence of): | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| c. | | | Due to (or as a consequence of): | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| d. | | | Due to (or as a consequence of): | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <table border="0" style="width:100%;"> <tr> <td style="width:70%;"> Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. </td> <td style="width:30%;"> 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown </td> </tr> <tr> <td> 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No </td> <td> 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No </td> </tr> </table> | | | | | | | | | | | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <table border="0" style="width:100%;"> <tr> <td style="width:30%;"> 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No </td> <td colspan="8"> 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) </td> </tr> <tr> <td> 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined </td> <td> 28a. Date of Injury (Month, Day Year) </td> <td> 28b. Time of Injury <div style="text-align: center;">M</div> </td> <td> 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No </td> <td colspan="7"> 28d. Describe how injury occurred </td> </tr> <tr> <td colspan="4"> 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) </td> <td colspan="7"> 28f. Location (Street and Number or Rural Route Number, City or Town, State) </td> </tr> </table> | | | | | | | | | | | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury <div style="text-align: center;">M</div> | 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | 28d. Describe how injury occurred | | | | | | | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury <div style="text-align: center;">M</div> | 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | 28d. Describe how injury occurred | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 29b. Signature and title of certifier V. Annmangadla | | | | | 29c. License number D26064 | | 29d. Date signed (Month, Day, Year) DECEMBER 8, 1997 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) V. ANMANGADLA, CHARLOTTE HALL, MD 20622 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 12 1997 | | | | | 32. Registrar's Signature J. H. Anderson | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

Baltimore, Maryland 21215-0020
 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,
 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38856

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

JOAN E. MONT

2. Date of Death

Month Day Year
DEC. 4, 1997

3. Time of Death

3:58AM

4a. Facility Name (If not institution, give street and number)

MONTGOMERY GENERAL HOSPITAL

4b. City, Town, or Location of Death

OLNEY

4c. County of Death

MONTGOMERY

Funeral
Director

5. Social Security Number

142-30-0486

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

60

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year
July 5, 1937

9. Birthplace (State or Foreign Country)

New Jersey

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3530 Chiswick Court

10f. Zip Code

20906

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Manager

16b. Kind of Business/Industry

Credit Union

17. Father's Name (First, Middle, Last)

Harold

18. Mother's Name (First, Middle, Maiden Surname)

Claire Lazowitz

19a. Informant's Name/Relationship (Type, Print)

Irving Mont-Spouse

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3530 Chiswick Ct. Silver Spring, MD 20906

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☒ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Mt. Lebanon Cemetery

Date

12/5/97

20c. Location - City or Town, State

Woodbridge, NJ

21. Signature of Funeral Service Licensee

DANIEL SIMONS

22. Name and Address of Facility

EDWARD SAGEL FUNERAL DIRECTION, INC.
1091 ROCKVILLE PIKE, ROCKVILLE, MD 20852

23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

congestive heart failure (per PR)

Due to (or as a consequence of):

b.

diastolic dysfunction

Due to (or as a consequence of):

c.

DIABETES (TYPE II)

Due to (or as a consequence of):

d.

chronic renal failure

Approximate Interval Between Onset and Death

25

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

P.M.R.

cushingsoid state 2-4 prednisone

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)

2 ☒ Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Edgar R. Miller IV M.D., PhD 2024 S. Monument, Baltimore MD 21205

31. Date filed (Month, Day, Year)

DEC 08 1997

32. Registrar's Signature

21205

State
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 38857

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

GLADYS MORRIS

2. Date of Death

Month Day Year
December 10, 1997 7:00 AM

3. Time of Death

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Laurel Regional Hospital

4b. City, Town, or Location of Death

Laurel

4c. County of Death

Prince George's

5. Social Security Number

215-26-3477

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

77 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year
Aug. 6, 1920

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

College Park

10d. Inside City Limits

XX Yes 2 ☐ No

10e. Street and Number

5803 Chestnut Hill Road

10f. Zip Code

20740

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Cafeteria Assistant

16b. Kind of Business/Industry

Prince George's Co. Board of Education

17. Father's Name (First, Middle, Last)

Soloman O. Barnes

18. Mother's Name (First, Middle, Maiden Surname)

Sina DeHaven

19a. Informant's Name/Relationship (Type, Print)

Caulder B. Morris (Husband)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Same as #10

20a. Method of Disposition

XX Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Fort Lincoln Cemetery 12/12/1997

Data

20c. Location - City or Town, State

Brentwood, Maryland

21. Signature of Funeral Service Licensee

Donald V. Borgwardt

22. Name and Address of Facility

Donald V. Borgwardt Funeral Home, P.A.
4400 Powder Mill Rd. Beltsville, Maryland 20705

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Pneumonia
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.
Due to (or as a consequence of):c.
Due to (or as a consequence of):d.
Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Emphysema

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Andrew Kunkas, M.D.

29c. License number

D36716

29d. Date signed (Month, Day, Year)

December 10, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Andrew Kunkas, M.D., 8317 Cherry Lane, Laurel, MD 20707

31. Date filed (Month, Day, Year)

DEC 12 1997

32. Registrar's Signature

Julia Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38858

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Jasper Muse

2. Date of Death

December 05 1997

3. Time of Death

1557 P

4a. Facility Name (If not institution, give street and number)

SHADY GROVE ADVENTIST HOSPITAL

4b. City, Town, or Location of Death

ROCKVILLE

4c. County of Death

MONTGOMERY

5. Social Security Number

236-05-6017

6. Sex

M ☒ F ☐

7. Age (In yrs. last birthday)

85 Yrs.

8. Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

May 8, 1912

9. Birthplace (State or Foreign Country)

WVA

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Wheaton

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

12703 Bushey Drive

10f. Zip Code

20906

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12th

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Supply Clerk Manager

16b. Kind of Business/Industry

N.I.H.

17. Father's Name (First, Middle, Last)

Unknown

18. Mother's Name (First, Middle, Maiden Surname)

Bertha Muse

19a. Informant's Name/Relationship (Type, Print)

Elydian C. Muse (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12703 Bushey Drive, Wheaton, MD 20906

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Lincoln Park Cem.

Date

12/12/97

20c. Location - City or Town, State

Rockville, MD

21. Signature of Funeral Service Licensee

George R. Snowden

22. Name and Address of Facility

SNOWDEN FUNERAL HOME, P.A.
ROCKVILLE, MD 20850

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Hyperkalemia

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 day

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Prostate Carcinoma

Due to (or as a consequence of):

9 years

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

David A Holden MD

29c. License number

047791

29d. Date signed (Month, Day, Year)

December 06, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

David A Holden MD 809 Veirs mill Rd Rockville MD 20851

31. Date filed (Month, Day, Year)

DEC 08 1997

32. Registrar's Signature

*Julia Davidson-Randall*State
Registrar

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

38859

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

FREDERICK MAYER

2. Date of Death

Month Day Year
DECEMBER 11 1997

3. Time of Death

3:18 PM

4a. Facility Name (If not institution, give street and number)

MONTGOMERY GENERAL HOSPITAL

4b. City, Town, or Location of Death

OLNEY

4c. County of Death

MONTGOMERY

5. Social Security Number

087 12 8749

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

89 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
MAY 22, 1908

9. Birthplace (State or Foreign Country)

GERMANY

Usual Residence of Decedent

10a. State

MD

10b. County

MONTGOMERY

10c. City, Town or Location

SILVER SPRING

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

14400 HOMECREST ROAD #51

10f. Zip Code

20906

10g. Citizen of What Country?

UNITED STATES

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No -
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: WHITE

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

1

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

SHIPPING CLERK

16b. Kind of Business/Industry

WOMEN'S CLOTHING

17. Father's Name (First, Middle, Last)

ADOLPH MAYER

18. Mother's Name (First, Middle, Maiden Surname)

GUTA KATHERINA REINHEIMER

19a. Informant's Name/Relationship (Type, Print)

GARRY MAYER SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2 ELMWOOD COURT ROCKVILLE MD 20850

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

JUDEAN MEMORIAL GARDENS

Date

12/12/97

20c. Location - City or Town, State

OLNEY MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

DANZANSKY-GOLDBERG MEMORIAL CHAPELS INC

1170 ROCKVILLE PIKE, ROCKVILLE MD 20852

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a. CONGESTIVE HEART FAILURE

DAYS

Due to (or as a consequence of):

b. COMPLETE HEART BLOCK

DAYS

Due to (or as a consequence of):

c. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE

YEARS

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

PNEUMONIA

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of causa
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

29c. License number

D37930

29d. Date signed (Month, Day, Year)

DECEMBER 11, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ROBERT A. KNITZER MD 1811 Prince Philip Dr Ste 312 OLNEY, MD 20852

31. Date filed (Month, Day, Year)

DEC 12 1997

32. Registrar's Signature

Julia Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38860

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

GERTRUDE

MAYER

2. Date of Death

Month Day Year
DECEMBER 9, 1997

3. Time of Death

4:40 AM

4a. Facility Name (If not institution, give street and number)

ASPEN ASSISTED LIVING

4b. City, Town, or Location of Death

SILVER SPRING

4c. County of Death

MONTGOMERY

5. Social Security Number

090-14-0397

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

85 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
JUNE 6, 1912

9. Birthplace (State or Foreign Country)

GERMANY

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

MONTGOMERY

10c. City, Town or Location

SILVER SPRING

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

14400 HOMECREST ROAD, APT. #51

10f. Zip Code

20906

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
if Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: WHITE

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12

Collage (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

SALES

16b. Kind of Business/Industry

CLOTHING MANUFACTURE

17. Father's Name (First, Middle, Last)

ADOLPH STRAUSS

18. Mother's Name (First, Middle, Maiden Surname)

ADELTHENA WEINBERGER

19a. Informant's Name/Relationship (Type, Print)

GARRY MAYER/SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2 ELMWOOD COURT, ROCKVILLE, MARYLAND 20850

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

JUDEAN MEMORIAL GARDENS

Date

12/12/97

20c. Location - City or Town, State

OLNEY, MARYLAND

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC.
1170 ROCKVILLE PIKE - ROCKVILLE, MARYLAND 2085223a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. METASTATIC MALIGNANT MELANOMA

Due to (or as a consequence of):

YEARS

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury at
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

29c. License number

D37930

29d. Date signed (Month, Day, Year)

DECEMBER 9, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ROBERT H. KNITZER - 18111 PRINCE PHILIP DRIVE #312 - OLNEY, MARYLAND 20832

31. Date filed (Month, Day, Year)

DEC 10 1997

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Amend # 15, 12/16/97, BMW, Montg. Co.
Amended #2, 12/12/97, JW, Mont per FMD

38861

Physician
/Medical
Examiner

Funeral
Director

1. Decedent's Name (First, Middle, Last)

BILLIE L. MADLE

2. Date of Death
Month Day Year
December 3, 1997

3. Time of Death
11:11 A.M.

4a. Facility Name (If not institution, give street and number)

Montgomery General Hospital

4b. City, Town, or Location of Death

Olney

4c. County of Death

Montgomery

5. Social Security Number

246-01-0258

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

78 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

Aug. 31, 1919

9. Birthplace (State or Foreign Country)

North Carolina

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Rockville

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

4406 Bestor Drive

10f. Zip Code

20853

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12

College (1-4 or 5+)
1

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Home

17. Father's Name (First, Middle, Last)

Claude Lindsay

18. Mother's Name (First, Middle, Maiden Surname)

Predie Reeves

19a. Informant's Name/Relationship (Type, Print)

Robert A. Madle - Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4406 Bestor Drive, Rockville, Maryland 20853

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Parklawn Memorial Park

Date

12-8-97

20c. Location - City or Town, State

Rockville, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Hines-Rinaldi Funeral Home, Inc.

11800 New Hampshire Ave., Silver Spring, MD 20904

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Ischemic Cardiomyopathy

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Coronary Artery Disease

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Ventricular Tachycardia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No

Hospital: 1 ☐ Inpatient 2 ☒ Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?
1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D21334

29d. Date signed (Month, Day, Year)

December 5, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Daniel Goldenberg 6116 Executive Blvd Rockville MD 20852

31. Date filed (Month, Day, Year)

DEC 08 1997

32. Registrar's Signature

John Davidson-Randall

State
Registrar

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38862

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Francille Peoples Mack

2. Date of Death

December 09 1997

3. Time of Death

0835 A

4a. Facility Name (If not institution, give street and number)

SHADY GROVE ADVENTIST HOSPITAL

4b. City, Town, or Location of Death

ROCKVILLE

4c. County of Death

MONTGOMERY

Funeral
Director

5. Social Security Number

557-44-7464

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

66

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

May 8, 1931

9. Birthplace (State or Foreign Country)

Louisiana

Usual Residence of Decedent

10a. State

LA

10b. County

Madison

10c. City, Town or Location

Tallulah

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

806 N. Madison Street

10f. Zip Code

71282

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify Black

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12th

College (1-4 or 5+)

18e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Teachers Aide

16b. Kind of Business/Industry

Education

17. Father's Name (First, Middle, Last)

Artis Peoples

18. Mother's Name (First, Middle, Maiden Surname)

Shirley Wright

19a. Informant's Name/Relationship (Type, Print)

Felecia M. Wilson (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

20604 Hartsbourne Way, Germantown, MD 20874

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☒ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Tennant Mortuary

Date

12/10/97

20c. Location - City or Town, State

Rayville, LA

21. Signature of Funeral Service Licensee

George R. Snowden

22. Name and Address of Facility

SNOWDEN FUNERAL HOME, P.A.
ROCKVILLE, MD 20850

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

HEMORRHAGIC MUCOSTOMATITIS

10 DAYS

Due to (or as a consequence of):

PLATELET AUTOIMMUNIZATION

5 DAYS

Due to (or as a consequence of):

CHEMOTHERAPY RELATED PANCYTOPENIA

20 DAYS

Due to (or as a consequence of):

LOCALLY ADVANCED NONINFLAMMATORY BREAST CANCER

6 MONTHS

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

RENAL FAILURE REQUIRING DIALYSIS

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Carolyn Hendricks MD

29c. License number

D37236

29d. Date signed (Month, Day, Year)

DECEMBER, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

CAROLYN HENDRICKS MD

9707 MEDICAL CENTER DRIVE

ROCKVILLE MD 20850

31. Date filed (Month, Day, Year)

DEC 10 1997

32. Registrar's Signature

*Julia Davidson-Randall*State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38863

| | | | | | | | | |
|---|--|---|--|---|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) KIL YU OH | | | | 2. Date of Death Month Dec Day 4 Year 1997 | | 3. Time of Death 11:20 PM | |
| | 4a. Facility Name (If not institution, give street and number) Holy Cross Hospital | | | | 4b. City, Town, or Location of Death Silver Spring | | 4c. County of Death Montgomery | |
| Funeral Director | 5. Social Security Number 213-88-7572 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 91 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) Sept. 29, 1906 | 9. Birthplace (State or Foreign Country) Korea |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State Maryland | | 10b. County Montgomery | | 10c. City, Town or Location Potomac | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 10e. Street and Number 10100 Chapel Road | | | | 10f. Zip Code 20854 | | 10g. Citizen of What Country? Korea | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Korean | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4or 5+) 0 | | | | 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker | | 16b. Kind of Business/Industry Home | | |
| 17. Father's Name (First, Middle, Last) Min Soo Shim | | | | | 18. Mother's Name (First, Middle, Maiden Surname) Unknown | | | |
| 19a. Informant's Name/Relationship (Type, Print) Sooyoung Oh - Son | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1030 Bay Front Avenue, North Beach, Maryland 20714 | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Norbeck Memorial Park | | 20c. Location - City or Town, State 12-8-97 Olney, Maryland | | |
| 21. Signature of Funeral Service Licensee <i>[Signature]</i> | | | | 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, MD 20904 | | | | |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. a. Acute renal failure b. Aspiration pneumonia c. d. | | | | | | | | 23b. Dld tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| 23c. Part 2. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. a. Acute renal failure b. Aspiration pneumonia c. d. | | | | | | | | 23d. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Dementia. Status Post Gastrostomy tube. | | | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | | | |
| 28a. Date of Injury (Month, Day, Year) | | | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | 29b. Signature and title of certifier Murarka MD |
| 29c. License number D29816 | | | | 29d. Date signed (Month, Day, Year) Dec 5, 1997 | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Radhey Murarka 50 West Edmonston Avenue, Suite 604, Rockville, Maryland 20854 | | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 8 1997 | | | | 32. Registrar's Signature <i>[Signature]</i> | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permits. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38864

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Catherine E. O'Brien

2. Date of Death

Month Day Year
December 4, 1997

3. Time of Death

9:55 PM

4a. Facility Name (If not institution, give street and number)

Rockville Nursing Home

4b. City, Town, or Location of Death

Rockville

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

018-18-1278

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

95

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Dec. 30, 1901

9. Birthplace (State or Foreign Country)

Massachusetts

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Rockville

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

303 Adclare Road

10f. Zip Code

20850

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Secretary

16b. Kind of Business/Industry

Medical

17. Father's Name (First, Middle, Last)

Robert Michael Meehan

18. Mother's Name (First, Middle, Maiden Surname)

Mary McHale

19a. Informant's Name/Relationship (Type, Print)

Mary Meehan / Niece

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

759 Azalea Drive, Rockville, Maryland 20850

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

St. Joseph's Cemetery

Date

December 9, 1997

20c. Location - City or Town, State

Boston, Massachusetts

21. Signature of Funeral Service Licensee

[Signature] M00803

22. Name and Address of Facility Robert A. Pumphrey Funeral Home/
Bethesda-Chevy Chase, Inc., 7557 Wisconsin Ave.
Bethesda, Maryland 20850-280523a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Stroke

Due to (or as a consequence of):

b. Congestive Heart Failure

Due to (or as a consequence of):

Sequently list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury at
Work?
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

[Signature] M.D.

29c. License number

D19785

29d. Date signed (Month, Day, Year)

December 5, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Frauke Westphal, M.D., 809 Veirs Mill, Rockville, Maryland 20850

31. Date filed (Month, Day, Year)

DEC 10 1997

32. Registrar's Signature

[Signature]

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 38865

| | | | | | | | | |
|--|--|---|--|--|---|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) BARBARA TURNER PATTERSON | | | | 2. Date of Death Month Dec. Day 4 Year 1997 | | 3. Time of Death 11:30am | |
| | 4e. Facility Name (If not institution, give street and number) Washington Adventist Hospital | | | | 4b. City, Town, or Location of Death Takoma Park | | 4c. County of Death Montgomery | |
| Funeral Director | 5. Social Security Number 124-24-9475 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 65 Yrs. | | 8. Date of Birth (Month, Day, Year) May 21, 1932 | |
| | 9. Birthplace (State or Foreign Country) Washington, D.C. | | 10a. State Maryland | | 10b. County Prince Georges | | 10c. City, Town or Location Hyattsville | |
| 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number 700 Sheridan Street | | 10f. Zip Code 20783 | | 10g. Citizen of What Country? United States | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever In U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Black | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 5+ College (1-4or 5+) 5+ | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Educator | | 16b. Kind of Business/Industry Public Schools | | 17. Father's Name (First, Middle, Last) John G. Goodlett | | |
| 18. Mother's Name (First, Middle, Maiden Surname) Marjorie Brooks | | 19. Informant's Name/Relationship (Type, Print) Kimberlee Willis /daughter | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1104 Chillum Manor Road, Hyattsville, Md. 20783 | | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | |
| 20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Olivet Cemetery | | 20c. Location - City or Town, State Washington, D.C. | | 21. Signature of Funeral Service Licensee | | 22. Name and Address of Facility McGuire Funeral Service, Inc. 7400 Georgia Ave. N.W., Washington, D.C. | | |
| 23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last a. Respiratory Failure Due to (or as a consequence of): b. Cardiac Arrest Due to (or as a consequence of): c. Sepsis Due to (or as a consequence of): d. Leukemia | | Approximate Interval Between Onset and Death 7 days 15 min 10 days 2 months | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Pneumonia Anemia Renal failure | | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | |
| 29b. Signature and title of certifier | | 29c. License number D17843 | | 29d. Date signed (Month, Day, Year) 12/6/97 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Vivek C VAIDM-D 3311 Toledo Terrace # B102 Hyattsville Md. | | |
| 31. Date filed (Month, Day, Year) DEC 08 1997 | | 32. Registrar's Signature | | 33. State Registrar | | 34. Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020 | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 38866

Certificate of Death

Reg. No.

| | | | | | | | | | |
|--|---|---|---|---|---|---|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) LAWRENCE PLUMMER | | | | 2. Date of Death Month December Day 4 Year 1997 | | 3. Time of Death 0950 | | |
| | 4a. Facility Name (If not institution, give street and number) SHADY GROVE ADVENTIST HOSPITAL | | | | 4b. City, Town, or Location of Death ROCKVILLE | | 4c. County of Death MONTGOMERY | | |
| Funeral Director | 5. Social Security Number 579-38-6571 | | 6. Sex 1 <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 76 Yrs. | | 8. Date of Birth (Month, Day, Year) Aug. 18, 1921 | | |
| | 9. Birthplace (State or Foreign Country) Maryland | | 10a. State MD | | 10b. County Montgomery | | 10c. City, Town or Location Gaithersburg | | |
| Usual Residence of Decedent | | 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number 7925 Spiceberry Court #A | | 10f. Zip Code 20877 | | 10g. Citizen of What Country? U.S.A. | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Black | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11th | | 15a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Bus Attendant | | 15b. Kind of Business/Industry Montg. Co. Schools | | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Bus Attendant | | | |
| 17. Father's Name (First, Middle, Last) Harry Plummer | | 18. Mother's Name (First, Middle, Maiden Summa) Lottie Smith | | 19a. Informant's Name/Relationship (Type, Print) Irene E. Plummer (Wife) | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7925 Spiceberry Ct., #A, Gaithersburg, MD 20877 | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) John Wesley Cem. | | 20c. Date 12/8/97 | | 20d. Location - City or Town, State Clarksburg, MD | | | |
| 21. Signature of Funeral Service Licensee <i>George R. Snowden</i> | | 22. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A. ROCKVILLE, MD 20850 | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. a. Urosepsis / Septic Shock Due to (or as a consequence of): b. Flaccid quadriplegia Due to (or as a consequence of): c. Infarction - cervical spinal cord Due to (or as a consequence of): d. | | Approximate Interval Between Onset and Death 4 days 6 mons 6 mons | | | |
| 23a. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. malnutrition, depression, decubitus ulcers | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 29a. Certifier (Check only one) 2 <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier <i>Robert Millman</i> | | 29c. License number D13977 | | 29d. Date signed (Month, Day, Year) December 4, 1997 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robert Millman MD 9207 Medical Center Dr Rockville, Md 20850 | | 31. Date filed (Month, Day, Year) DEC 08 1997 | | 32. Registrar's Signature <i>John Davidson</i> | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

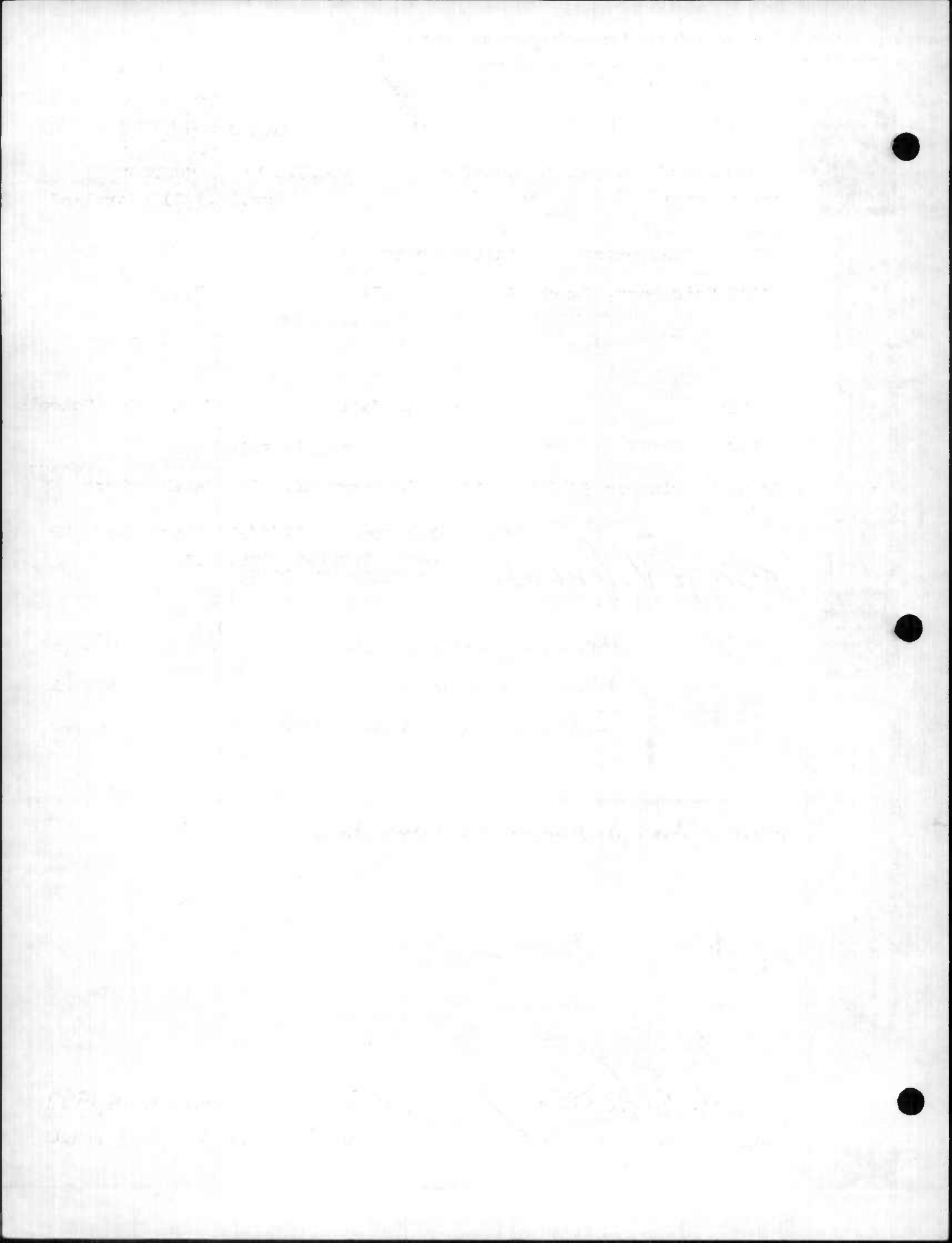
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38867

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

Mariette N. Pouliot

2. Date of Death

Month Day Year
December 5, 1997

3. Time of Death

12:45 AM

4a. Facility Name (If not institution, give street and number)

Villa Rosa Home

4b. City, Town, or Location of Death

Mitchellville

4c. County of Death

Prince George's

5. Social Security Number

026-05-3604

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

86

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Feb. 3, 1911

9. Birthplace (State or Foreign Country)

Massachusetts

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Lanham

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

9203 Fowler Lane

10f. Zip Code

20706-2453

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever In U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.Specify:
White15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

8

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Clothing Inspector

16b. Kind of Business/Industry

Garment

17. Father's Name (First, Middle, Last)

Timothee Fillion

18. Mother's Name (First, Middle, Maiden Surname)

Angelique Boudria

19a. Informant's Name/Relationship (Type, Print)

Roland Pouliot (husband)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9203 Fowler Lane Lanham, Maryland 20706-2453

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☒ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Notre Dame Cemetery

Date

12/9/97

20c. Location - City or Town, State

Massachusetts

Fall River,

21. Signature of Funeral Service Licensee

Tracy A. Stuver

22. Name and Address of Facility

Francis J. Collins Funeral Home, Inc.

500 University Blvd., W., Silver Spring, MD 20901

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Hypertensive Cardiovascular disease

Due to (or as a consequence of):

years

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Last

b. Multiple Cerebral Infarct

Due to (or as a consequence of):

years

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Gastrostomy feeding tube

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
2 ☐ Accident investigation
3 ☐ Suicide 6 ☐ Could not be
4 ☐ Homicide determined28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Rakesh Arora, MD

29c. License number

D20108

29d. Date signed (Month, Day, Year)

12/5/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Rakesh Arora, M.D.

14300 Gallant Fox Lane #222 Bowie, Maryland 20715

31. Date filed (Month, Day, Year)

DEC 10 1997

32. Registrar's Signature

John Davidson-Rendell

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38868

| | | | | | | | | | | |
|--|--|----------------------------------|---|--|--|---|--|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) JAMES B. PUGH | | | | | | 2. Date of Death Month DEC Day 5 Year 1997 | | 3. Time of Death 3:14 Am | |
| | 4a. Facility Name (If not institution, give street and number) MONTGOMERY GENERAL HOSPITAL | | | | | | 4b. City, Town, or Location of Death OLNEY | | 4c. County of Death MONTGOMERY | |
| Funeral Director | 5. Social Security Number 213-66-3024 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 41 Yrs. | | 8. Date of Birth (Month, Day, Year) Feb. 29, 1956 | | 9. Birthplace (State or Foreign Country) Maryland | |
| | Usual Residence of Decedent | | | | | | | | | |
| 10a. State MD | | 10b. County Montgomery | | 10c. City, Town or Location Sandy Spring | | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 10e. Street and Number 19008 Chandlee Mill Road | | | | | | 10f. Zip Code 20860 | | 10g. Citizen of What Country? U.S.A. | | |
| 11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: Black | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11th College (1-4 or 5+) College | | | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Technician | | 16b. Kind of Business/Industry Jiffy Lube | | |
| 17. Father's Name (First, Middle, Last) James Campbell | | | | | | 18. Mother's Name (First, Middle, Maiden Surname) Estelle Pugh | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Sarah Walker (Sister) | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19008 Chandlee Mill Rd., Sandy Spring, MD 20860 | | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Mutual Mem. Cemetery | | | Date 12/11/97 | | 20c. Location - City or Town, State Sandy Spring, MD | | |
| 21. Signature of Funeral Service Licensee <i>George R. Maudslow</i> | | | | | | 22. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A. ROCKVILLE, MD 20850 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Amyloidosis Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Approximate Interval Between Onset and Death 2 months | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | | | | | | | | |
| 24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | |
| 25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how Injury occurred | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | |
| 29b. Signature and title of certifier <i>H. H. H.</i> | | | | | | 29c. License number D35635 | | 29d. Date signed (Month, Day, Year) December 05, 1997 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOSEPH KAPLAN 1811 Prince Philip Dr. OLNEY, MD 20832 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 10 1997 | | | | | | 32. Registrar's Signature <i>John Davidson</i> | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

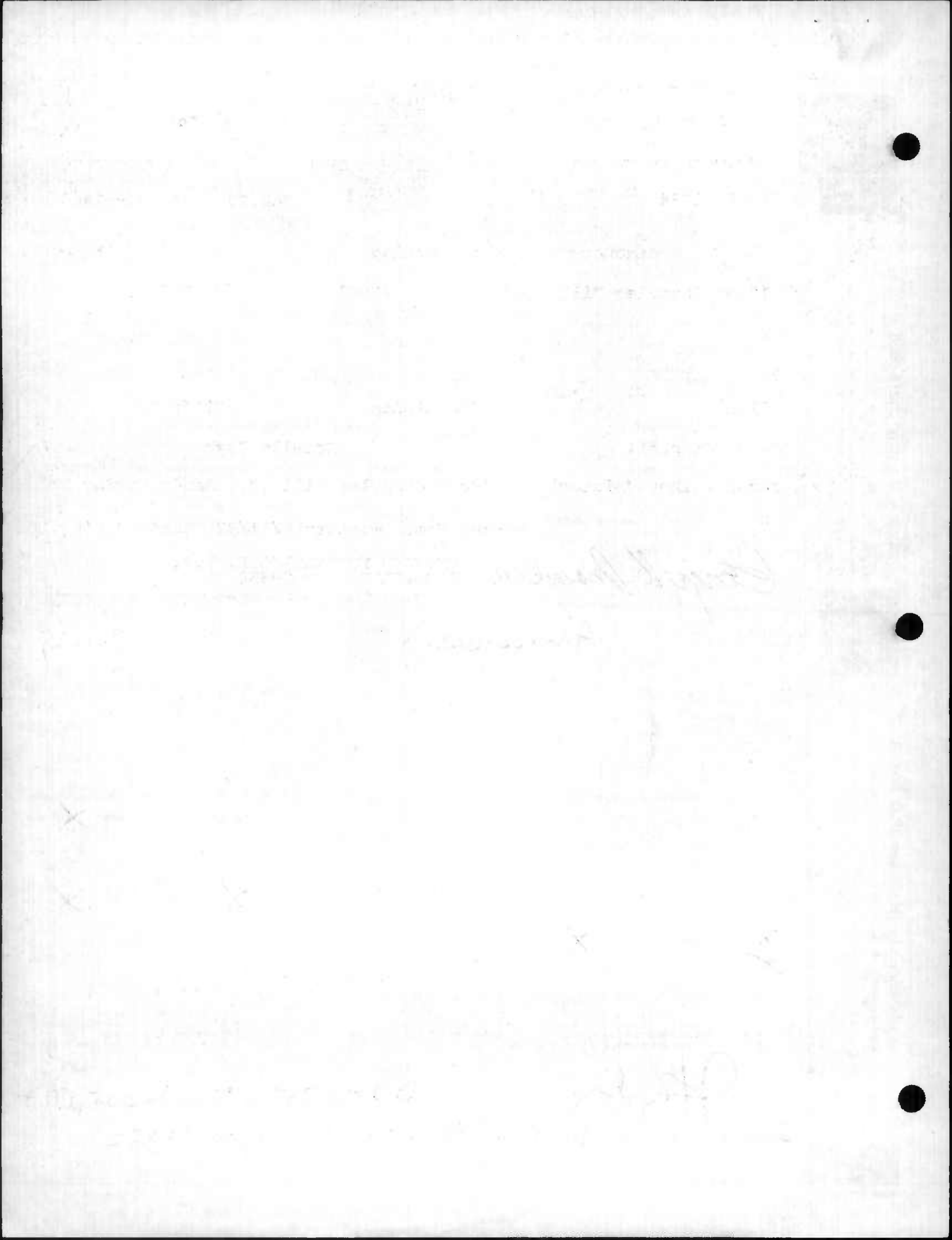
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar




Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38869

| | | | | | | | | |
|---|---|--|---|--|--|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) HOWARD REESE | | | | 2. Date of Death Month Dec Day 5 Year 1997 | | 3. Time of Death 0441 | |
| | 4a. Facility Name (If not Institution, give street and number) LAUREL REGIONAL HOSPITAL | | | | 4b. City, Town, or Location of Death LAUREL | | 4c. County of Death PRINCE GEORGES | |
| Funeral Director | 5. Social Security Number 213-40-6549 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 64 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) Feb. 26, 1933 | 9. Birthplace (State or Foreign Country) Maryland |
| | Usual Residence of Decedent | | | | | | | |
| To Be Completed by Funeral Director | 10a. State MD | 10b. County Prince Georges | 10c. City, Town or Location Laurel | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | 10e. Street and Number 198 Easton South, Tall Oaks | | | | 10f. Zip Code 20724 | | 10g. Citizen of What Country? U.S.A. | |
| | 11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever In U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Black | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) | | 15a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Maintenance worker | | 16b. Kind of Business/Industry Apartment Bldg. | | | |
| 17. Father's Name (First, Middle, Last) William Reese | | | | 18. Mother's Name (First, Middle, Maiden Surname) Edna Thomas | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Charles Smith (Brother) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9000 Briarcroft Ln., #126, Laurel, MD20708 | | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) MD Nat'l Memorial Pk. | | 20c. Location - City or Town, State 12/11/97 Laurel, MD | | |
| 21. Signature of Funeral Service Licensee  | | | | 22. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A. ROCKVILLE, MD 20850 | | | | |
| Physician /Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | Approximate Interval Between Onset and Death |
| | Immediate Cause (Final disease or condition resulting in death) Laryngeal Cancer | | | | | | | months |
| | Due to (or as a consequence of): Hypertension | | | | | | | Years |
| | Due to (or as a consequence of): Coronary artery Disease | | | | | | | Years |
| Due to (or as a consequence of): Diabetes mellitus | | | | | | | Years | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | |
| 27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. Describe how injury occurred | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier  | | | | 29c. License number D 28998 | | 29d. Date signed (Month, Day, Year) Dec 7, 97 | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) PRITHAM S. SAMI MD | | | | 9101 Cherry Ln H 211 Laurel MD 20708 | | | | |
| 31. Date filed (Month, Day, Year) DEC 8 1997 | | 32. Registrar's Signature  | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "Natural", or items 23a or 24a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38870

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

MARGUERITE RHOADS

2. Date of Death

Month Day Year
DECEMBER 10, 1997

3. Time of Death

12:41 AM

4a. Facility Name (If not institution, give street and number)

LAUREL REGIONAL HOSPITAL

4b. City, Town, or Location of Death

LAUREL

4c. County of Death

PRINCE GEORGES

Funeral
Director

5. Social Security Number

577-46-8659

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

62 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
June 24, 1935

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Beltsville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

12207 Myrtle Avenue

10f. Zip Code

20705

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

9

College (14 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Key punch operator

16b. Kind of Business/Industry

Private

17. Father's Name (First, Middle, Last)

Francis R. Clark

18. Mother's Name (First, Middle, Maiden Surname)

Ruth Regina Reese

19a. Informant's Name/Relationship (Type, Print)

Linda McConahy (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7248 Montgomery Road Elkridge, Maryland 21075

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Fort Lincoln cemetery 12/16/1997 Brentwood, Maryland

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Donald V. Borgwardt

22. Name and Address of Facility

Donald V. Borgwardt Funeral Home, P.A.
4400 Powder Mill Road Beltsville, Maryland 20705

23a. Pert I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a. CHRONIC OBSTRUCTIVE PULMONARY DISEASE AND

Due to (or as a consequence of)

b. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE

Due to (or as a consequence of)

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

c. Due to (or as a consequence of)

d. Due to (or as a consequence of)

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation
6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Mario F. Golub Jr. MD

29c. License number

DME 033954

29d. Date signed (Month, Day, Year)

DECEMBER 11, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

MARIO F. GOLUB JR MD, 3001 HOSPITAL DRIVE, CHEVERLY, MARYLAND 20785

State
Registrar

31. Date filed (Month, Day, Year)

DEC 12 1997

32. Registrar's Signature

Shirley Davidson-Randall

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

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Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38871

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

DERWOOD ROBERTS

2. Date of Death

Month

Day

Year

DEC

6

1997

3. Time of Death

4:15 PM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

NATIONAL NAVAL MEDICAL CENTER

4b. City, Town, or Location of Death

BETHESDA

4c. County of Death

MONTGOMERY

5. Social Security Number

579-52-4022

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

82

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

June 26, 1915

9. Birthplace (State or Foreign Country)

Missouri

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Kensington

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3502 Stark Street

10f. Zip Code

20895

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (14 or 5+)

12

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Electronic Technician

16b. Kind of Business/Industry

Federal Government

17. Father's Name (First, Middle, Last)

Lee Roberts

18. Mother's Name (First, Middle, Maiden Surname)

Roda Cruse

19a. Informant's Name/Relationship (Type, Print)

Mary Catherine Roberts (wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3502 Stark Street Kensington, Maryland 20895

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Gate of Heaven Cemetery

Date

12/10/97

20c. Location - City or Town, State

Silver Spring, Maryland

21. Signature of Funeral Service Licensee

Robert E Ramsey

22. Name and Address of Facility

Francis J. Collins Funeral Home, Inc.

500 University Blvd., W., Sil. Spr., Maryland 20901

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

CHRONIC OBSTRUCTIVE PULMONARY DISEASE

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
2 ☐ Accident investigation
3 ☐ Suicide 6 ☐ Could not be
4 ☐ Homicide determined

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

P.D. Kane

29c. License number

194374-1 (NY)

29d. Date signed (Month, Day, Year)

12/8/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

P.D. KANE, LCDR, MC, USN

NATIONAL NAVAL MEDICAL CENTER

BETHESDA MD 20889-5600

31. Date filed (Month, Day, Year)

DEC 10 1997

32. Registrar's Signature

John Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38872

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

MARION L ROSEMAN

2. Date of Death

Month Day Year
December 07, 1997

3. Time of Death

1:01 PM

4a. Facility Name (If not institution, give street and number)

Washington Adventist Hospital

4b. City, Town, or Location of Death

Takoma Park

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

180-24-1261

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

66 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Jan. 5, 1931

9. Birthplace (State or Foreign Country)

PA

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

13701 Middlevale Lane

10f. Zip Code

20906

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (14 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Clerical Support

16b. Kind of Business/Industry

Real Estate

17. Father's Name (First, Middle, Last)

Benjamin Zanan

18. Mother's Name (First, Middle, Maiden Surname)

Mollie Fuchs

19a. Informant's Name/Relationship (Type, Print)

Philip Roseman-son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

16017 Copen Meadow Dr. Gaithersburg, MD 20878

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

King David MG

Date

12/9/97

20c. Location - City or Town, State

Falls Church, VA

21. Signature of Funeral Service Licensee

Edward Sagel

22. Name and Address of Facility

Edward Sagel Funeral Direction
1091 Rockville Pike Rockville, MD 20852

23a. Part I. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. respiratory arrest

Approximate Interval Between Onset and Death

One hour

Due to (or as a consequence of):

b. cerebrovascular accident

ten days

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

renal failure

congestive heart failure

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D25881

29d. Date signed (Month, Day, Year)

December 07, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Joann URQUHART 9711 Medical Center Drive Suite 300 Rockville, Maryland

31. Date filed (Month, Day, Year)

DEC 12 1997

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38873

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ALMA ROSS

2. Date of Death

Month
12Day
4Year
97

3. Time of Death

5:30 pm

4a. Facility Name (If not institution, give street and number)

Woodside Center

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

578-32-7319

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

87

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

December 2, 1910

9. Birthplace (State or Foreign Country)

LaCrosse, VA

Usual Residence of Decedent

10a. State

10b. County

10c. City, Town or Location

Washington, D.C.

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

608 Oglethorpe Street

10f. Zip Code

20011

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: Colored

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Dressmaker

16b. Kind of Business/Industry

Clothing

17. Father's Name (First, Middle, Last)

Reuben A. Jiggetts

18. Mother's Name (First, Middle, Maiden Surname)

Lelia Jackson

19a. Informant's Name/Relationship (Type, Print)

Clara Lee/niece

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11246B Snowflake Court, Columbia, MD 21044

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Rock Creek Cemetery

Date

12/12/97

20c. Location - City or Town, State

Washington, D.C.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

McGuire Funeral Service, Inc.

7400 Georgia Avenue, N.W., Washington, D.C.

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Due to (or as a consequence of):

Pancreatic Cancer

Approximate
Interval Between
Onset and Death

6 months

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D42578

29d. Date signed (Month, Day, Year)

DEC 05, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Gul Chablan, MD 11119 Rockville Pike #316, Rockville, MD 20852

State
Registrar

31. Date filed (Month, Day, Year)

DEC 11 1997

32. Registrar's Signature

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.

100-111-111

100-111-111

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38874

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Sara Watkins Shirley-Quirk

2. Date of Death

Month Day Year
December 2, 1997

3. Time of Death

9:27 P.M.

4a. Facility Name (If not institution, give street and number)

Suburban Hospital

4b. City, Town, or Location of Death

Bethesda

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

341-36-0300

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

52

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Oct. 12, 1945

9. Birthplace (State or Foreign Country)

Illinois

Usual Residence of Decedent

10e. State

Maryland

10f. County

Howard

10g. City, Town or Location

Clarksville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6062 Red Clover Lane

10f. Zip Code

21029

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Conductor

16b. Kind of Business/Industry

Music

17. Father's Name (First, Middle, Last)

John Watkins

18. Mother's Name (First, Middle, Maiden Surname)

Virginia Marthens

19e. Informant's Name/Relationship (Type, Print)

John Shirley-Quirk/Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6062 Red Clover Lane
Clarksville, Maryland 21029

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Dec. 9, 1997
Montgomery Crematorium, Inc.

Date

20c. Location - City or Town, State

Bethesda, Maryland

21. Signature of Funeral Service Licensee

Raymond J. Smith

M00198

22. Name and Address of Facility Robert A. Pumphrey Funeral Home/
Bethesda-Chevy Chase, Inc., 7557 Wisconsin Ave.
Bethesda, Maryland 20814-3501

23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Ventricular Arrhythmia

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

15 Minutes

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No25. Was case referred to medical examiner?
1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural
2 ☐ Accident
3 ☐ Suicide
4 ☐ Homicide5 ☐ Pending Investigation
6 ☐ Could not be determined

28e. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Bruce M. Conger, M.D. Internist

29c. License number

D37013

29d. Date signed (Month, Day, Year)

December 5, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Bruce M. Conger, M.D. 11055 Little Patuxent Parkway, Columbia, Maryland 21044

31. Date filed (Month, Day, Year)

DEC 10 1997

32. Registrar's Signature

Julia Davidson-Rodriguez

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Paul Jones

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38875

| | | | | | | | | | | |
|---|--|---|--|---|--|--|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Thaddeus Sims | | | | | | 2. Date of Death Month December Day 7 Year 1997 | | 3. Time of Death 9:35 AM | |
| | 4a. Facility Name (If not institution, give street and number) MONTGOMERY GENERAL HOSPITAL | | | | | | 4b. City, Town, or Location of Death OLNEY | | 4c. County of Death MONTGOMERY | |
| Funeral Director | 5. Social Security Number 213-34-3946 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 85 Yrs. | | 8. Date of Birth (Month, Day, Year) MAR. 22, 1912 | | 9. Birthplace (State or Foreign Country) GEORGIA | |
| | Usual Residence of Decedent | | | | | | | | | |
| 10a. State MD. | | 10b. County MONTGOMERY | | 10c. City, Town or Location SILVER SPRING | | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 10e. Street and Number 3473 SOUTH LEISURE WORLD BLVD. | | | | | | 10f. Zip Code 20906 | | 10g. Citizen of What Country? U.S.A. | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever In U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WWII | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4 Collage (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) FEDERAL EMPLOYEE | | | 16b. Kind of Business/Industry GOV'T | | | |
| 17. Father's Name (First, Middle, Last) JOHN E. SIMS | | | | | | 18. Mother's Name (First, Middle, Maiden Surname) NELLIE REVEE GARRICK | | | | |
| 19a. Informant's Name/Relationship (Type, Print) ELIZABETH SIMS/WIFE | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SAME AS ITEM #10 | | | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) CHAMBERS CREMATORY | | Data 12/9/97 | | 20c. Location - City or Town, State RIVERDALE, MD. | | |
| 21. Signature of Funeral Service Licensee  | | | | 22. Name and Address of Facility SILVER SPRING, MD. M00091 CHAMBERS FUNERAL HOMES, P.A. 20910 | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Acute Cerebral Bleeding Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | | | | | | | | | Approximate Interval Between Onset and Death one Day |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| | | | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | | | | 28d. Describe how injury occurred | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | 29b. Signature and title of certifier  | | | | 29c. License number 033686 | | |
| | | | | 29d. Date signed (Month, Day, Year) December 7, 1997 | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kenneth Miller, MD 1811 Prince Philip Dr. Olney, MD 20832 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 10 1997 | | | | 32. Registrar's Signature  | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38876

| | | | | | | | | |
|---|---|--|---|--|--|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Robert Josiah Small | | | | 2. Date of Death Month December Day 6 Year 1997 | | 3. Time of Death 3:25 PM | |
| | 4a. Facility Name (If not institution, give street and number) Greater Laurel Regional Hospital | | | | 4b. City, Town, or Location of Death Laurel | | 4c. County of Death Prince Georges | |
| Funeral Director | 5. Social Security Number 220-42-0248 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 84 Yrs. | | 8. Date of Birth (Month, Day, Year) July 17, 1913 | |
| | 9. Birthplace (State or Foreign Country) North Carolina | | 10a. State Maryland | | 10b. County Prince Georges | | 10c. City, Town or Location College Park | |
| To Be Completed by Funeral Director | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number 8405 Potomac Avenue | | 10f. Zip Code 20740 | | 10g. Citizen of What Country? USA | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 4 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Manager | | 16b. Kind of Business/Industry U. S. Dept. of Commerce | | | |
| | 17. Father's Name (First, Middle, Last) Henry F. Small | | | | 18. Mother's Name (First, Middle, Maiden Surname) Mary Ann Small | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Pauline Watkins / Daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 863 Bentley Green Circle, Winter Springs, FL 32708 | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Gate of Heaven Cemetery | | 20c. Location - City or Town, State 12/9/97 Silver Spring, Maryland | | 22. Name and Address of Facility Hines-Rinaldi Funeral Home 11800 New Hampshire Avenue Silver Spring, Maryland 20904 | |
| | 21. Signature of Funeral Service Licensee | | | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. coronary Artery Disease Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. many years Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. pneumonia urosepsis | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Piece of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residencia <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier H. B. [Signature] | | 29c. License number D23181 | | 29d. Date signed (Month, Day, Year) 12-7-97 | | |
| 30. Name and address of person who completed cause of death (item 23e) (Type, Print) R. G. BHOSRAJ, MD. 704 GORMAN AVE # T-1. LAUREL, MD 20707 | | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 10 1997 | | 32. Registrar's Signature [Signature] | | | | | | |

Baltimore, Maryland 21215-0020

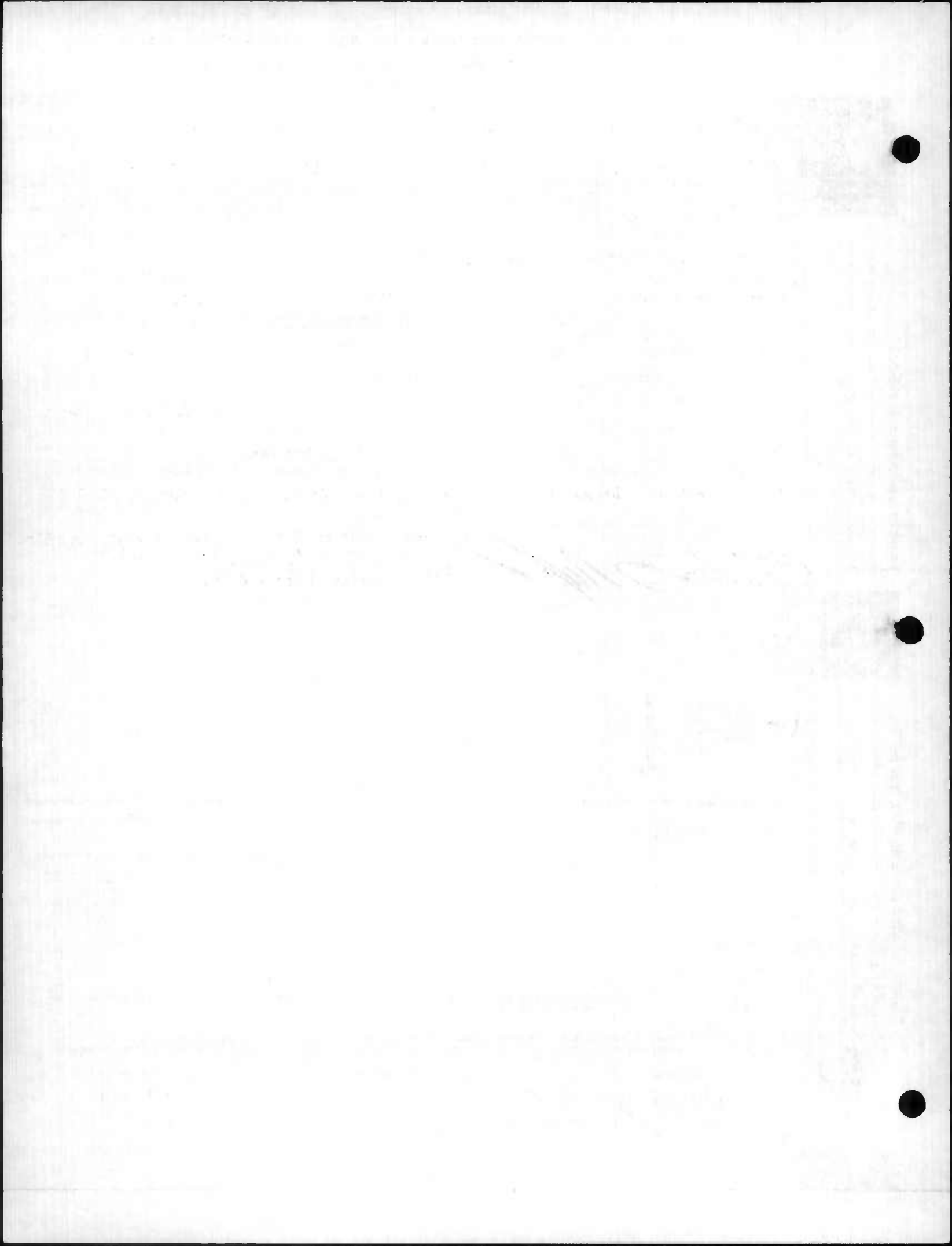
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 38877

Certificate of Death

Reg. No.

| | | | | | | | | | | | |
|---|---|---|---|---|--|---|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) MELVIN C. SMITH | | | | 2. Date of Death Month DEC. Day 7 Year 1997 | | | | 3. Time of Death 3:25 Am | | |
| | 4a. Facility Name (If not Institution, give street and number) 5804 Annapolis Road, #110 | | | | 4b. City, Town, or Location of Death Bladensburg | | | | 4c. County of Death Prince Georges | | |
| Funeral Director | 5. Social Security Number 578-70-6950 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 46 Yrs. | | 8. Date of Birth (Month, Day, Year) Mar 27, 1951 | | 9. Birthplace (State or Foreign Country) Maryland | | |
| | Usual Residence of Decedent | | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State MD | | 10b. County Prince Georges | | 10c. City, Town or Location Bladensburg | | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | 10e. Street and Number 5804 Annapolis Road, #110 | | | | 10f. Zip Code 20710 | | 10g. Citizen of What Country? U.S.A. | | | | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: Black | | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th | | College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Letter Carrier | | | 16b. Kind of Business/Industry U. S. Postal Serv. | | | |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last) Ozzie Mosley | | | | 18. Mother's Name (First, Middle, Maiden Surname) Mildred Smith | | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Janyce A. Smith (Wife) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5804 Annapolis Rd., #110, Bladensburg, MD 20710 | | | | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Md. Nat'l Mem. Park | | Date 12/13/97 | | 20c. Location - City or Town, State Laurel, MD | | | | |
| | 21. Signature of Funeral Service Licensee <i>[Signature]</i> | | | | 22. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A. ROCKVILLE, MD 20850 | | | | | | |
| Physician /Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Metastatic Colon Cancer | | | | | | | | Approximate Interval Between Onset and Death | | |
| | Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of): | | | | | | | | | | |
| | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): | | | | | | | | | | |
| | c. Due to (or as a consequence of): | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | |
| | | | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how Injury occurred | | | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | | |
| 29b. Signature and title of certifier <i>[Signature]</i> | | | | 29c. License number D 4321 | | | | 29d. Date signed (Month, Day, Year) 12/9/97 | | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) R.A. VAUNA, MD 5100 Auth Way, Marlow Hts Ctr, Suitland | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 10 1997 | | | | 32. Registrar's Signature <i>[Signature]</i> | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

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Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38878

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

LENA S. SNOWDEN

2. Date of Death

DEC. 8, 1997

3. Time of Death

2:00 P.

4a. Facility Name (If not Institution, give street and number)

30 Norwood Road

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

MONTGOMERY

Funeral
Director

5. Social Security Number

217-32-0984-A

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

104 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

Jul 21, 1893

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Md

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

30 Norwood Rd,

10f. Zip Code

20905

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8th Grade

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Housewife Will

16b. Kind of Business/Industry

Home E. King

17. Father's Name (First, Middle, Last)

Samuel T. Hill

18. Mother's Name (First, Middle, Maiden Surname)

Mary K. King

19a. Informant's Name/Relationship (Type, Print)

Mrs Lillian S. Wallace

(Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

30 Norwood Rd, Silver Spring, Md 20905

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Mutual Cemetery

Date

12/15/97 Sandy Spring, Md

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Snowden Funeral Home P.A. 20850
246 N. Washington St, Rockville, Md

23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CHRONIC RENAL FAILURE

TERM.

Due to (or as a consequence of):

b. ARTERIOCLER WEPHROSCLEROSIS

YRS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. A.S.C.V.D.

YRS

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

MULTI-STROKES

DIABETES

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D06406

29d. Date signed (Month, Day, Year)

DECEMBER 9, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DONALD R. LEWIS MD

4000 RT103 OLNEY, MD 20832

31. Date filed (Month, Day, Year)

DEC 10 1997

32. Registrar's Signature

State
RegistrarBaltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

Reg. No.

97 38879

**Physician
/Medical
Examiner**

1. Decedent's Name (First, Middle, Last)

Gertrude B. Sommerhalter

2. Date of Death

Month Day Year
December 3, 1997

3. Time of Death

2240PM

4a. Facility Name (If not institution, give street and number)

SHADY GROVE ADVENTIST HOSPITAL

4b. City, Town, or Location of Death

ROCKVILLE

4c. County of Death

MONTGOMERY

5. Social Security Number

076-20-9332

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

74 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Oct. 5, 1923

9. Birthplace (State or Foreign Country)

New Jersey

Usual Residence of Decedent

10a. State

New Jersey

10b. County

Bergen

10c. City, Town or Location

Paramus

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

743 Arbor Road

10f. Zip Code

07652

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

William Burke

18. Mother's Name (First, Middle, Maiden Surname)

Lillian Fallon

19a. Informant's Name/Relationship (Type, Print)

Karl L. Sommerhalter/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

14956 Carry Back Drive, North Potomac, MD 20878

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

George Washington Memorial Park

Date

Dec. 8, 1997

20c. Location - City or Town, State

Paramus, New Jersey

21. Signature of Funeral Service Licensee

David E. Perry M00803

22. Name and Address of Facility

Robert A. Pumphrey Funeral Home/
Rockville, Inc. 300 West Montgomery Avenue
Rockville, Maryland 20850-2805

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Hypoxic respiratory failure
Due to (or as a consequence of):

Approximate interval Between Onset and Death

4 hrs

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Endobronchial obstruction
Due to (or as a consequence of):

2 wks

c. Bronchogenic carcinoma
Due to (or as a consequence of):

11 mos

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

acetabular fracture, humeral head

fracture x tmo

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24e. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient

2 ☒ Outpatient

3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

David E. Perry

29c. License number

D33443

29d. Date signed (Month, Day, Year)

December 3, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

809 Viers Mill Rd Rockville, Md 20851

31. Date filed (Month, Day, Year)

DEC 10 1997

32. Registrar's Signature

Julia Davidson-Randall

**State
Registrar**

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Physician
/Medical
Examiner**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

87 38880

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Roland Collins Simpson, Sr.

2. Date of Death

Month Day Year
December 9, 1997

3. Time of Death

3:35 AM

4a. Facility Name (If not institution, give street and number)

Prince George's Hospital

4b. City, Town, or Location of Death

Cheverly

4c. County of Death

Prince George's

Funeral
Director

5. Social Security Number

577-44-0023

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

66 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Sept. 23, 1931

9. Birthplace (State or Foreign Country)

Washington, DC

Usual Residence of Decedent

10a. State

10b. County

10c. City, Town or Location

Washington, D.C.

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

4215 Blaine Street, N.E.

10f. Zip Code

20019

10g. Citizen of What Country?

United States

11. Marital Status

☐ Never Married ☐ Married☒ Widowed ☐ Divorced

12. Was Decedent Ever In U.S.

Armed Forces?

☒ Yes ☐ No

If Yes, Give

Year or Dates: 1952 -

1954

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: Black

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Manual Letter Sorter
Supervisor

16b. Kind of Business/Industry

U.S. Postal Service

17. Father's Name (First, Middle, Last)

James L. Simpson

18. Mother's Name (First, Middle, Maiden Surname)

Beatrice E. Harris

19a. Informant's Name/Relationship (Type, Print)

Rachel M. Simpson - Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4215 Blaine St., N.E. Washington, D.C. 20019

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Lincoln Memorial Cemetery

12/13/97

20c. Location - City or Town, State

Suitland, Maryland

21. Signature of Funeral Service Licensee

Lynne McGuire

22. Name and Address of Facility McGuire Funeral Service, Inc.

7400 Georgia Ave., N.W. Washington, D.C.

20012

Approximate
Interval Between
Onset and Death

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

Cardiogenic Shock

Due to (or as a consequence of):

b.

Acute Myocardial Infarction few hrs

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☒ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☒ Inpatient ☐ ER/Outpatient ☐ DOA

28. Place of Death (Check only one)

Other: ☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Accident☐ Suicide☐ Homicide☐ Pending Investigation☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Lynne McGuire MD

29c. License number

D24283

29d. Date signed (Month, Day, Year)

12.10.97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M. YUSUF. 3450 Fort meade Road Laurel MD. 20724

31. Date filed (Month, Day, Year)

DEC 12 1997

32. Registrar's Signature

*Julia Davidson-Randall*State
Registrar

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

perma-Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38881

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | | | | | | |
|--|--|---|--|--|--|---|--|--|--|
| 1. Decedent's Name (First, Middle, Last) Mary Margaret Sone | | | | | | 2. Date of Death Month Day Year December 8, 1997 | | 3. Time of Death 2:30 AM | |
| 4a. Facility Name (If not institution, give street and number) Care Matrix of Silver Spring | | | | 4b. City, Town, or Location of Death Silver Spring | | 4c. County of Death Montgomery | | | |
| 5. Social Security Number 561-38-0950 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 69 Yrs. | | 8. Date of Birth (Month, Day, Year) Aug. 30, 1928 | | 9. Birthplace (State or Foreign Country) Ohio | |
| Usual Residence of Decedent | | | | | | | | | |
| 10a. State MD | | 10b. County Montgomery | | 10c. City, Town or Location Silver Spring | | | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| 10e. Street and Number 8500 16th Street #314 | | | | 10f. Zip Code 20910 | | 10g. Citizen of What Country? USA | | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Collega (1-4or 5+) 5+ | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Administrative Assistant | | | 16b. Kind of Business/Industry Federal Government | | |
| 17. Father's Name (First, Middle, Last) John Parkkila | | | | | | 18. Mother's Name (First, Middle, Maiden Surname) Hilma Mary Anderson | | | |
| 19a. Informant's Name/Relationship (Type, Print) John William Sone (son) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7804 Strathdon Court, Alexandria, VA 22315 | | | | | |
| 20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory | | 20c. Date 12/9/97 | | 20d. Location - City or Town, State Alexandria, VA | | | |
| 21. Signature of Funeral Service Licensee Steven D. Stroud | | | | 22. Name and Address of Facility Francis J. Collins Funeral Home, Inc. 500 University Blvd. West Silver Spring, MD 20901 | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Cardiac arrhythmia Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death 5 mins | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Fractured left hip | | | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | |
| 25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input checked="" type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) Sept 25 1997 | | 28b. Time of Injury unk M | | 28c. Injury at Work? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred fell | |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Building | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) Smithsonian Institution | | | | | | | |
| 29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier John T. Sone | | 29c. License number D08546 | | 29d. Date signed (Month, Day, Year) Dec 8 1997 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) John T. Sone 8218 Wisconsin Ave Bethesda | | | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 09 1997 | | 32. Registrar's Signature John Davidson-Randall | | | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Amend #19a, 12/16/97, BMW Montg. Co.
Amend #1, 12/15/97, BMW Montg. Co.

State of Maryland / Department of Health and Mental Hygiene

87 38882

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|---|-------------------------------|---|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Elizabeth A. Shepherd Shepherd | | | | 2. Date of Death Month Day Year December 3, 1997 | | 3. Time of Death 11:45 PM | |
| | 4a. Facility Name (If not institution, give street and number) Larkin Chase/Rehabilitation & Nursing Center | | | | 4b. City, Town, or Location of Death Bowie | | 4c. County of Death Prince Georges | |
| Funeral Director | 5. Social Security Number 578-36-2304 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 69 Yrs. | | 8. Date of Birth (Month, Day, Year) May 12, 1928 | |
| | 9. Birthplace (State or Foreign Country) Washington, DC | | 10a. State MD | | 10b. County Prince Georges | | 10c. City, Town or Location Adelphi | |
| To Be Completed by Funeral Director | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 10e. Street and Number 1919 Saratoga Drive | | 10f. Zip Code 20783 | | 10g. Citizen of What Country? USA | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 3 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker | | 16b. Kind of Business/Industry Own Home | | | |
| | 17. Father's Name (First, Middle, Last) John Poetzman | | | | 18. Mother's Name (First, Middle, Maiden Surname) Margaret Crismond | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Robert M. Shepherd (son) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3417 Riva Road, Davidsonville, MD 21035 | | | |
| | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Gate of Heaven Cemetery | | Date 12/9/97 | | 20c. Location - City or Town, State Silver Spring, MD | |
| | 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility Francis J. Collins Funeral Home, Inc. 500 University Blvd. West Silver Spring, MD 20901 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Hepatic failure Due to (or as a consequence of): b. Sepsis Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | | | | | |
| | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Small Cell Carcinoma of Lung | | | | | | | |
| | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| State Registrar | 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| | 29b. Signature and title of certifier | | 29c. License number D45660 | | 29d. Date signed (Month, Day, Year) 12-4-97 | | | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Definder Singh 3060, Mitchellville Rd, Bowie MD 20716 | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 05 1997 | | 32. Registrar's Signature | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38883

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Francis Pritchard Saulsbury

2. Date of Death

Month Day Year
December 8, 1997

3. Time of Death

12:51 PM

4a. Facility Name (If not institution, give street and number)

Montgomery General Hospital

4b. City, Town, or Location of Death

Olney

4c. County of Death

Montgomery

5. Social Security Number

577-30-1632

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

70 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Jan. 31, 1927

9. Birthplace (State or Foreign Country)

Washington, DC

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Olney

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

18808 Stoneyhurst Street

10f. Zip Code

20832

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (14 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Cartographer

16b. Kind of Business/Industry

Federal Government

17. Father's Name (First, Middle, Last)

Gould Saulsbury

18. Mother's Name (First, Middle, Maiden Surname)

Rose Pritchard

19a. Informant's Name/Relationship (Type, Print)

Marguerite L. Saulsbury (wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

18808 Stoneyhurst Street, Olney, MD 20832

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Gate of Heaven Cemetery

Date

12/11/97

20c. Location - City or Town, State

Silver Spring, MD

21. Signature of Funeral Service Licensee

► *Steven D. Stoney*

22. Name and Address of Facility

Francis J. Collins Funeral
Home, Inc. 500 University Blvd. West
Silver Spring, MD 2090123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. SEVERE CHRONIC OBSTRUCTIVE PULMONARY DISEASE 4 YEARS

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☒ Yes 2 ☐ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury at
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

► *Abed Ali Khan M.D.*

29c. License number

D43323

29d. Date signed (Month, Day, Year)

DECEMBER 9, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ABEDA ALI KHAN M.D.
18111 PRINCE PHILIP DRIVE SUITE 212 OLNEY MD 20832

31. Date filed (Month, Day, Year)

DEC 10 1997

32. Registrar's Signature

J. A. Davidson-Rodriguez

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 38884

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last) WILLIAM H. SCOTT
2. Date of Death Month DEC 4, Day 1997 Year
3. Time of Death 6:30 Pm

Funeral
Director

4a. Facility Name (If not institution, give street and number) Mariner of Kensington
4b. City, Town, or Location of Death Kensington
4c. County of Death MONTGOMERY

5. Social Security Number 220-18-4700
6. Sex ☒ M ☐ F
7. Age (In yrs. last birthday) 76 Yrs.
8. Date of Birth (Month, Day, Year) Sept. 21, 1921
9. Birthplace (State or Foreign Country) Maryland

Usual Residence of Decedent
10a. State MD
10b. County Montgomery
10c. City, Town or Location Olney
10d. Inside City Limits ☒ Yes ☐ No

10e. Street and Number 3329 Buehler Court
10f. Zip Code 20832
10g. Citizen of What Country? U.S.A.

11. Marital Status
1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc.
Specify: Black

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 5th
College (1-4 or 5+)
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Laborer
16b. Kind of Business/Industry City of Rockville

17. Father's Name (First, Middle, Last) Henry Scott
18. Mother's Name (First, Middle, Maiden Surname) Macey Williams

19a. Informant's Name/Relationship (Type, Print) Gladys Scott (Daughter)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 329 Buehler Ct., Olney, MD 20832

20a. Method of Disposition
1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crem.
Date 12/10/97
20c. Location - City or Town, State Alexandria, VA

21. Signature of Funeral Service Licensee
22. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A.
ROCKVILLE, MD 20850

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death) a. Sepsis
Due to (or as a consequence of):
b. Urinary tract Infection
Due to (or as a consequence of):
c. Dehydration
Due to (or as a consequence of):
d.
Approximate Interval Between Onset and Death 24°
48°
one week

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
cerebrovascular Accident
23b. Did tobacco use contribute to the cause of death?
1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?
1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one)
Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
Other: ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death
1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier
29c. License number D41931
29d. Date signed (Month, Day, Year) December 5, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print) R Shumacher MD 2309 Shumacher Rd Wheaton MD 20902

31. Date filed (Month, Day, Year) DEC 8 1997
32. Registrar's Signature Julia Davidson-Rodale

State
Registrar

Baltimore, Maryland 21215-0020

permits. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

George R. Smith

Please Type or Print in Black Indeleible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 38885

Amended #20b, 12/12/97, JW Mont. per F H

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Mary Ellen Sanders

2. Date of Death

Month

Day

Year

November 30, 1997

3. Time of Death

10:20 A.M.

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Wilson Health Care Center

4b. City, Town, or Location of Death

Gaithersburg

4c. County of Death

Montgomery

5. Social Security Number

579-20-9522

8. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

74

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

May 16, 1923

9. Birthplace (State or Foreign Country)

California

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Potomac

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

12413 Over Ridge Road

10f. Zip Code

20854

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Harold N. Gilbert

18. Mother's Name (First, Middle, Maiden Summa)

Sara Katherine Metzger

19a. Informant's Name/Relationship (Type, Print)

Douglas G. Sanders / son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12413 Over Ridge Road, Potomac, Maryland 20854

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Greenwood Cemetery

Date

December 9, 1997

20c. Location - City or Town, State

Tarboro, North Carolina

21. Signature of Funeral Service Licensee

M00831

Barbara J. McMillen Lawrence

22. Name and Address of Facility

Robert A. Pumphrey Funeral Home/Rockville, Inc.

300 West Montgomery Avenue, Rockville, Maryland 20850-2805

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Pneumonia

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

6 Days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Alzheimer's Disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

28. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation2 ☐ Accident3 ☐ Suicide4 ☐ Homicide6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(a) and manner as stated.

29b. Signature and title of certifier

Elliot R. Goldstein

29c. License number

D03581

29d. Date signed (Month, Day, Year)

November 30, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Elliot R. Goldstein 9410 Old Georgetown Road, Bethesda, Md. 20814

31. Date filed (Month, Day, Year)

DEC 10 1997

32. Registrar's Signature

Julia Davidson-Rodriguez

State
Registrar

Baltimore, Maryland 21215-0020

penn. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38886

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Mildred Sarah Taplin

2. Date of Death

Month Day Year
December 6, 1997

3. Time of Death

6:35 AM

Funeral
Director

4e. Facility Name (If not institution, give street and number)

10216 Tenbrook Drive

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

5. Social Security Number

364-16-1588

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

85

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
October 10, 1912

9. Birthplace (State or Foreign Country)

Michigan

Usual Residence of Decedent

10e. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

10216 Tenbrook Drive

10f. Zip Code

20901

10g. Citizen of What Country?

United States

11. Marital Status

☐ Never Married ☐ Married☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

☐ Yes ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-
if Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16e. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Social Worker

16b. Kind of Business/Industry

Home Health

17. Father's Name (First, Middle, Last)

Jacob E. Stocker

18. Mother's Name (First, Middle, Maiden Surname)

Pauline King

19e. Informant's Name/Relationship (Type, Print)

Philip N. Taplin (son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4700 Connecticut Avenue, NW, Apt. 606, Washington, DC 20008

20e. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Chesapeake Crematory

Date

12-7-97

20c. Location - City or Town, State

Beltsville, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Rapp Funeral Services, P.A.

933 Gist Avenue, Silver Spring, Maryland 20910

23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

e. Congestive Heart Failure

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

2 years

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Depression

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown24e. Was an autopsy
performed?☐ Yes ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?☐ Yes ☐ No25. Was case referred to medical
examiner?☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient☐ ER/Outpatient☐ DOA

Other:

☐ Nursing Home☒ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Accident☐ Suicide☐ Homicide☐ Pending

investigation

☐ Could not be

determined

28e. Date of Injury

(Month, Day Year)

28b. Time of

Injury

28c. Injury at

Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)☒ Certifying Physician:☐ Medical Examiner:To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

29c. License number

D20367

29d. Date signed (Month, Day, Year)

December 6, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Joel Kalman, M.D., 6111 Executive Boulevard, Rockville, Maryland 20852

31. Date filed (Month, Day, Year)

DEC 8 1997

32. Registrar's Signature

John Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

pages 1 and 2 should be filled within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 23e-4 show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

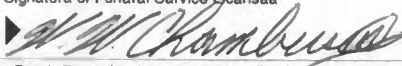

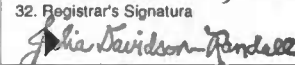
Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible:

State of Maryland / Department of Health and Mental Hygiene 97 38887

Certificate of Death

Reg. No.

| | | | | | | | | | |
|---|---|--|---|--|---|--------------------------------|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) ROBERT G. TAYLOR | | | | 2. Date of Death Month December Day 5 Year 1997 | | 3. Time of Death 1:55AM | | |
| | 4a. Facility Name (If not institution, give street and number) DOCTORS HOSPITAL | | | | 4b. City, Town, or Location of Death LANHAM | | 4c. County of Death PRINCE GEORGES | | |
| Funeral Director | 5. Social Security Number 395-20-8050 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 70 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) OCT. 9, 1927 | 9. Birthplace (State or Foreign Country) WISCONSIN | |
| | Usual Residence of Decedent | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State MD. | | 10b. County PRINCE GEORGES | | 10c. City, Town or Location BOWIE | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | 10e. Street and Number 2936 TALLOW LA. | | | | 10f. Zip Code 20715 | | 10g. Citizen of What Country? U.S.A. | | |
| | 11. Marital Status <input type="checkbox"/> Navar Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WWII | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Collage (1-4 or 5+) 5+ | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) NAVAL ARCHITECT | | 16b. Kind of Business/Industry U.S. NAVY | | | | |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last) BYRON E. TAYLOR | | | | 18. Mother's Name (First, Middle, Maiden Surname) HELEN GERTRUDE ASH | | | | |
| | 19a. Informant's Name/Relationship (Type, Print) MARYAN E. TAYLOR/WIFE | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SAME AS ITEM #10 | | | | |
| | 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) CHAMBERS CREMATORY | | Date 12/6/97 | | 20c. Location - City or Town, State RIVERDALE, MD. | | |
| | 21. Signature of Funeral Service Licensee  MO0091 | | 22. Name and Address of Facility CHAMBERS FUNERAL HOMES, P.A., RIVERDALE, MD. 20737 | | | | | | |
| Physician /Medical Examiner | 23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Acute myocardial infarction Due to (or as a consequence of): Coronary atherosclerosis Hypertension Due to (or as a consequence of): Cerebral aneurysm, seizure disorder, Subdural hematoma, Hypertension, Chronic obstructive lung disease, Carcinoma of the lung | | | | | | | Approximate Interval Between Onset and Death minutes yes | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| State Registrar | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28d. Describe how injury occurred | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier  MD | | 29c. License number D 24720 | | 29d. Date signed (Month, Day, Year) 12-05-97 | | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RAVINDER K. RUSTAGI MD 6132 Landover Rd, Chevy Chase MD 20785 | | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 08 1997 | | 32. Registrar's Signature  | | | | | | | |

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020
permitted. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38888

Physician
/Medical
Examiner

Funeral
Director

| | | | | | | | |
|--|--|---|--|--|--------------------------------|--|--|
| 1. Decedent's Name (First, Middle, Last) Catherine M. Thompson | | | | 2. Date of Death Month December Day 7 Year 1997 | | 3. Time of Death 3:30 A.M. | |
| 4a. Facility Name (If not institution, give street and number) 9 Mills Road | | | | 4b. City, Town, or Location of Death Gaithersburg | | 4c. County of Death Montgomery | |
| 5. Social Security Number 219-36-8398 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 91 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) June 11, 1906 | |
| 9. Birthplace (State or Foreign Country) Pennsylvania | | | | | | | |
| Usual Residence of Decedent | | | | | | | |
| 10a. State Md. | | 10b. County Montgomery | | 10c. City, Town or Location Gaithersburg | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10e. Street and Number 9 Mills Road | | | | 10f. Zip Code 20877 | | 10g. Citizen of What Country? United States | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: No | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 2 College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Teacher | | 16b. Kind of Business/Industry Public Schools | |
| 17. Father's Name (First, Middle, Last) James Murray | | | | 18. Mother's Name (First, Middle, Maiden Surname) Maggie McGarry | | | |
| 19a. Informant's Name/Relationship (Type, Print) Maureen Thompson (Daughter) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7330 Piney Branch Rd. Takoma Park, Md. 20912 | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Gate of Heaven Cemetery | | Date Dec. 11 1997 | | 20c. Location - City or Town, State Silver Spring, Md. | |
| 21. Signature of Funeral Service Licensee Curtis E. Day | | | | 22. Name and Address of Facility DeVol Funeral Home 10 East Deer Park Dr., Gaithersburg, MD. 20877 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Dehydration + Cachexia Due to (or as a consequence of): b. Multi-infarct Dementia Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | | | | | | |
| 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| 29b. Signature and title of certifier Norton L. Fishman MD | | | | 29c. License number 00050126 | | 29d. Date signed (Month, Day, Year) 12-8-97 | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Dr. Norton L. Fishman M.D. 11140 Rockville Pike Suite #600 Rockville, Md. 20852 | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 10 1997 | | | | 32. Registrar's Signature John Davidson-Rondella | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020
permits. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38890

| | | | | | | | | | | | | | | | | | | |
|---|---|---|---|--|---|--|---|--|---|---|---|--|--|---------------|---|---------------|----|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) VINH VAN TRAN | | | | 2. Date of Death Month December Day 3 Year 1997 | | 3. Time of Death 16:30 | | | | | | | | | | | |
| | 4a. Facility Name (If not Institution, give street and number) SHADY GROVE ADVENTIST HOSPITAL | | | | 4b. City, Town, or Location of Death ROCKVILLE | | 4c. County of Death MONTGOMERY | | | | | | | | | | | |
| Funeral Director | 5. Social Security Number 219-02-4594 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 79 Yrs. | | 8. Date of Birth (Month, Day, Year) Dec. 15, 1917 | | | | | | | | | | | |
| | 9. Birthplace (State or Foreign Country) Vietnam | | 10a. State Maryland | | 10b. County Montgomery | | 10c. City, Town or Location Gaithersburg | | | | | | | | | | | |
| To Be Completed by Funeral Director | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number 16509 Sioux Lane | | 10f. Zip Code 20878 | | 10g. Citizen of What Country? United States | | | | | | | | | | | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Asian | | | | | | | | | | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4or 5+) 4 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Accountant | | 16b. Kind of Business/Industry Banking | | | | | | | | | | | | | |
| | 17. Father's Name (First, Middle, Last) Duoc Van Tran | | | | 18. Mother's Name (First, Middle, Maiden Surname) Hoa T. Nguyen | | | | | | | | | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Christine Tran/Daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16509 Sioux Lane, Gaithersburg, Maryland 20878 | | | | | | | | | | | | | |
| | 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Montgomery Crematorium, Inc. | | 20c. Location - City or Town, State Bethesda, Maryland | | | | | | | | | | | | | |
| | 21. Signature of Funeral Service Licensee Daniel E. Perry M00803 | | 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/ Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850-2805 | | | | | | | | | | | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | | | | | | |
| | <table border="1"> <tr> <td>Immediate Cause (Final disease or condition resulting in death)</td> <td>a. cardiogenic shock Due to (or as a consequence of):</td> <td>Approximate Interval Between Onset and Death 48 hrs</td> </tr> <tr> <td rowspan="3">Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</td> <td>b. cardiomyopathy Due to (or as a consequence of):</td> <td>1 year</td> </tr> <tr> <td>c. Adriamycin toxicity Due to (or as a consequence of):</td> <td>1 year</td> </tr> <tr> <td>d.</td> <td></td> </tr> </table> | | | | | | | | Immediate Cause (Final disease or condition resulting in death) | a. cardiogenic shock Due to (or as a consequence of): | Approximate Interval Between Onset and Death 48 hrs | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. cardiomyopathy Due to (or as a consequence of): | 1 year | c. Adriamycin toxicity Due to (or as a consequence of): | 1 year | d. | |
| | Immediate Cause (Final disease or condition resulting in death) | a. cardiogenic shock Due to (or as a consequence of): | Approximate Interval Between Onset and Death 48 hrs | | | | | | | | | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. cardiomyopathy Due to (or as a consequence of): | 1 year | | | | | | | | | | | | | | | | |
| | c. Adriamycin toxicity Due to (or as a consequence of): | 1 year | | | | | | | | | | | | | | | | |
| | d. | | | | | | | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. gastric cancer atrial fibrillation | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | | | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | | |
| | | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier D. Friedman MD | | 29c. License number 024971 | | 29d. Date signed (Month, Day, Year) December 4, 1997 | | | | | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Dennis Friedman 15225 SHADY GROVE Rd, Rockville MD | | | | | | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 10 1997 | | 32. Registrar's Signature John Davidson-Randall | | | | | | | | | | | | | | | | |

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38891

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

VALERIE PATERSON VOSBURGH

2. Date of Death

Month Day Year
December 3, 1997

3. Time of Death

11:55 PM

4a. Facility Name (If not institution, give street and number)

Suburban Hospital

4b. City, Town, or Location of Death

Bethesda

4c. County of Death

Montgomery

5. Social Security Number

579-48-3635

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

85 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Feb. 14, 1912

9. Birthplace (State or Foreign Country)

England

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Bethesda

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8500 W. Howell Road

10f. Zip Code

20817

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Writer / Editor

16b. Kind of Business/Industry

American Psychiatric Association

17. Father's Name (First, Middle, Last)

James Potter

18. Mother's Name (First, Middle, Maiden Surname)

Carol Mailins

19a. Informant's Name/Relationship (Type, Print)

Frederick G. Vosburgh/Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8500 W. Howell Road, Bethesda, Maryland 20817

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Dec. 5, 1997
Montgomery Crematorium, Inc.

Date

20c. Location - City or Town, State

Bethesda, Maryland

21. Signature of Funeral Service Licensee

Michael G. Kutta M00348

22. Name and Address of Facility Robert A. Pumphrey Funeral Home/
Bethesda-Chevy Chase, Inc., 7557 Wisconsin Ave.
Bethesda, Maryland 20814-3501

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a.

RESPIRATORY FAILURE

Due to (or as a consequence of):

b.

CONGESTIVE HEART FAILURE

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

BRONCHIECTASIS, PNEUMONIA, SEVERE

KYPHOSIS OF THORACIC SPINE

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

28. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Michael G. Kutta

29c. License number

026571

29d. Date signed (Month, Day, Year)

12/4/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

IRVING MIZUS, MD 4930 DELRAY AVE BETHESDA, MD 20814

31. Date filed (Month, Day, Year)

DEC 10 1997

32. Registrar's Signature

John Davidson

State Registrar

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

10/20/54

10/20/54

RECEIVED
10/20/54

10/20/54
10/20/54

10/20/54
10/20/54

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38892

| | | | | | | | | | | | | | | | | | | | | | | |
|---|---|---|--|--|--|---|---|-----------------|----------------------------------|--|-------------------------------|------------------|----------------------------------|--|--------------------------------------|------------------|--|----------------------------------|--|--|----|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Pamela D. Williams | | 2. Date of Death Month December Day 7 Year 1997 | | 3. Time of Death 0510AM | | | | | | | | | | | | | | | | | |
| | 4a. Facility Name (If not institution, give street end number) SHADY GROVE ADVENTIST HOSPITAL | | 4b. City, Town, or Location of Death ROCKVILLE | | 4c. County of Death MONTGOMERY | | | | | | | | | | | | | | | | | |
| Funeral Director | 5. Social Security Number 212-80-9132 | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 38 Yrs. | 8. Date of Birth (Month, Day, Year) March 29, 1959 | 9. Birthplace (State or Foreign Country) Maryland | | | | | | | | | | | | | | | | | |
| | Usual Residence of Decedent | | | | | | | | | | | | | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State Maryland | 10b. County Montgomery | 10c. City, Town or Location Gaithersburg | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | | | | | | | | | |
| | 10e. Street end Number 28 North Summit Drive, Apt. 302 | | 10f. Zip Code 20877 | | 10g. Citizen of What Country? United States | | | | | | | | | | | | | | | | | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | | | | | | | | | | | | | | | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Waitress | | 16b. Kind of Business/Industry Food Service | | | | | | | | | | | | | | | | | |
| | 17. Father's Name (First, Middle, Last) Richard F. Porter | | 18. Mother's Name (First, Middle, Maiden Surname) Dixie Davis | | | | | | | | | | | | | | | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Farmer L. Williams / husband | | 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 28 North Summit Drive, Apt. 302, Gaithersburg, Maryland 20877 | | | | | | | | | | | | | | | | | | | |
| | 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Montgomery Crematorium, Inc. | | 20c. Location - City or Town, State Bethesda, Maryland | | | | | | | | | | | | | | | | | |
| | 21. Signature of Funeral Service Licensee Barbara J. Mullend Lawrence | | 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 | | | | | | | | | | | | | | | | | | | |
| | 23a. Pertinent disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | | | | | | | | | | |
| | <table border="0"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last </td> <td>e. Acute respiratory distress syndrome</td> <td>one week</td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> </tr> <tr> <td>b. Radiation Enteritis</td> <td>six weeks</td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> </tr> <tr> <td>c. Metastatic cervical cancer</td> <td>ten weeks</td> <td></td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td colspan="3">d.</td> </tr> </table> | | | | | Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | e. Acute respiratory distress syndrome | one week | Due to (or as a consequence of): | | b. Radiation Enteritis | six weeks | Due to (or as a consequence of): | | c. Metastatic cervical cancer | ten weeks | | Due to (or as a consequence of): | | | d. | |
| Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | e. Acute respiratory distress syndrome | one week | | | | | | | | | | | | | | | | | | | | |
| | Due to (or as a consequence of): | | | | | | | | | | | | | | | | | | | | | |
| | b. Radiation Enteritis | six weeks | | | | | | | | | | | | | | | | | | | | |
| | Due to (or as a consequence of): | | | | | | | | | | | | | | | | | | | | | |
| c. Metastatic cervical cancer | ten weeks | | | | | | | | | | | | | | | | | | | | | |
| Due to (or as a consequence of): | | | | | | | | | | | | | | | | | | | | | | |
| d. | | | | | | | | | | | | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | | | | | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | | | | | | | | | | | | | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | | | |
| 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | | | | | | | | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | | | | | | | | | | | | | | | | | | | | |
| 28a. Date of injury (Month, Day, Year) | | | | | | | | | | | | | | | | | | | | | | |
| 28b. Time of injury M | | | | | | | | | | | | | | | | | | | | | | |
| 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | | | |
| 28d. Describe how injury occurred | | | | | | | | | | | | | | | | | | | | | | |
| 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | | | | | | | | | | | | | | | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | | | | | | | | | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | | | | | | | | | | | | | |
| 29b. Signature and title of certifier Albert Steren | | | | | | | | | | | | | | | | | | | | | | |
| 29c. License number D38682 | | | | | | | | | | | | | | | | | | | | | | |
| 29d. Date signed (Month, Day, Year) December 07, 1997 | | | | | | | | | | | | | | | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Albert Steren 10215 Fernwood Dr. #405 Bethesda, Maryland 20817 | | | | | | | | | | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 10 1997 | | | | | | | | | | | | | | | | | | | | | | |
| 32. Registrar's Signature Julia Davidson-Randall | | | | | | | | | | | | | | | | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

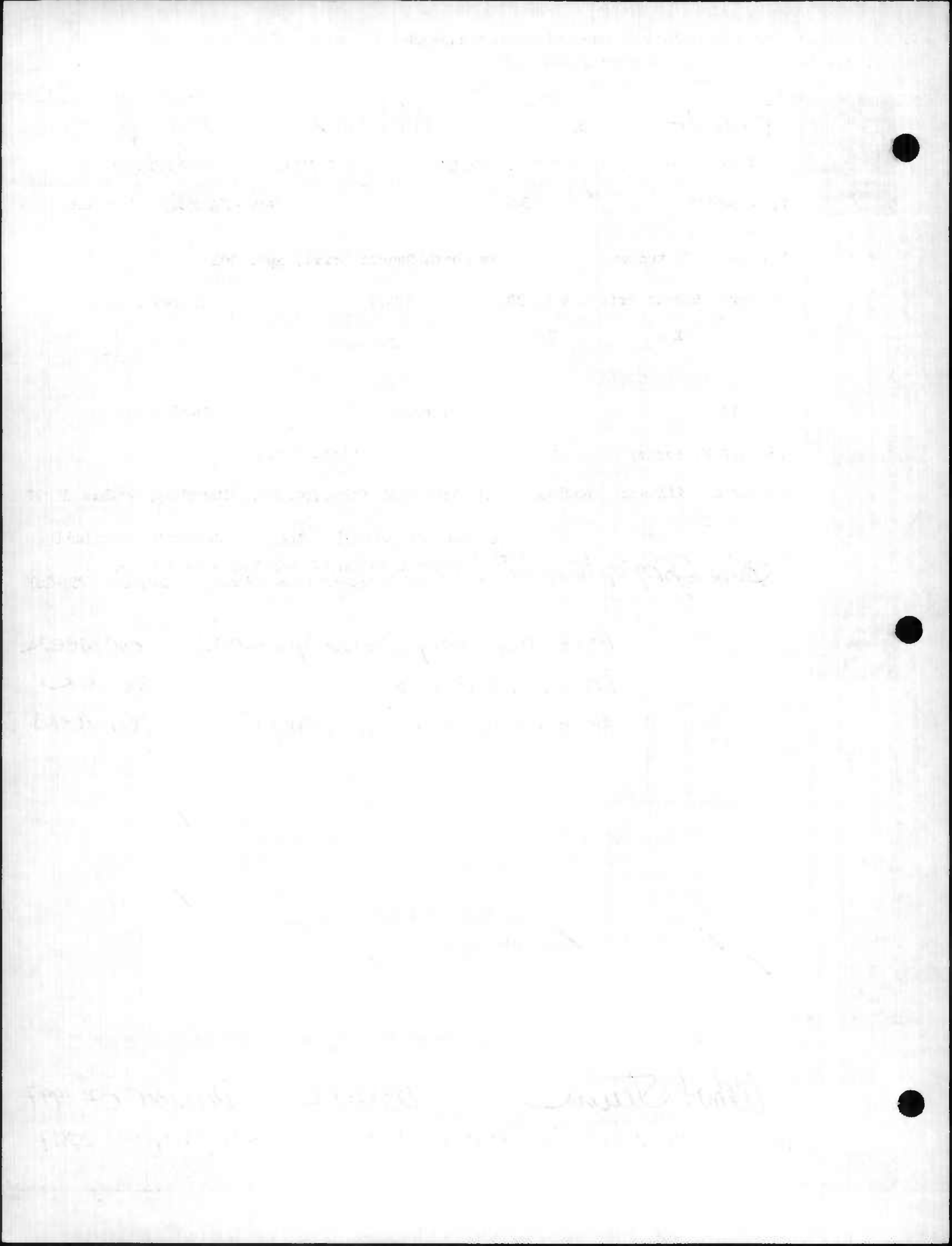
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **97 38893**
Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

HAROLD William WOOLLEY

2. Date of Death

Month Day Year
DECEMBER 09 1997

3. Time of Death

22:05 PM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

SHADY GROVE ADVENTIST HOSPITAL

4b. City, Town, or Location of Death

ROCKVILLE

4c. County of Death

MONTGOMERY

5. Social Security Number

578-58-8165

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

87 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
March 29, 1910

9. Birthplace (State or Foreign Country)

Michigan

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Rockville

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

9701 Medical Center Drive

10f. Zip Code

20850

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No.
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Theoretical Physicist

16b. Kind of Business/Industry

Federal Government

17. Father's Name (First, Middle, Last)

William Woolley

18. Mother's Name (First, Middle, Maiden Surname)

Ada Card

19a. Informant's Name/Relationship (Type, Print)

John W. Woolley/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1033 South Hoga Road, Sterling, Virginia 20164

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Parklawn Memorial Park

Date

December 13, 1997

20c. Location - City or Town, State

Rockville, Maryland

21. Signature of Funeral Service Licensee

Michael D. Higgins

M00846

22. Name and Address of Facility

Robert A. Pumphrey Funeral Home/Rockville, Inc.
300 West Montgomery Avenue, Rockville, Maryland 20850-280523a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

e. Multi infarct Dementia

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

5 years

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Cerebrovascular Accident

Due to (or as a consequence of):

5 years

c. Dehydration

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of
Injury

M

28c. Injury et
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Pankaj Lal MD

29c. License number

D 39671

29d. Date signed (Month, Day, Year)

DECEMBER 10, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PANKAJ LAL 11119 ROCKVILLE PIKE ROCKVILLE

31. Date filed (Month, Day, Year)

DEC 12 1997

32. Registrar's Signature

*Davidson-Randall*State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 38894

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

GLADYS

R.

WHITE

2. Date of Death

Month Day Year
DEC. 5, 1997

3. Time of Death

7:50 PM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

SPRING HOUSE---MANOR CARE

4b. City, Town, or Location of Death

BETHESDA

4c. County of Death

MONTGOMERY

5. Social Security Number

011-36-4810

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

84 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
FEB. 13, 1913

9. Birthplace (State or Foreign Country)

MASSACHUSETTS

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

MONTGOMERY

10c. City, Town or Location

BETHESDA

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

5101 RIDGEFIELD ROAD

10f. Zip Code

20816

10g. Citizen of What Country?

UNITED STATES

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

LIBRARIAN

16b. Kind of Business/Industry

PUBLIC LIBRARY

17. Father's Name (First, Middle, Last)

DAVID WHITE

18. Mother's Name (First, Middle, Maiden Surname)

MARY WINKELLER

19a. Informant's Name/Relationship (Type, Print)

ROBERT WHITE (BROTHER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5610 WISCONSIN AVE. - CHEVY CHASE, MARYLAND 20815

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☒ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

BETH EL CEMETERY

Date

12/8/97

20c. Location - City or Town, State

BOSTON, MASSACHUSETTS

21. Signature of Funeral Service Licensee

Frank A. Stone

22. Name and Address of Facility

DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC.
1170 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. CONGESTIVE HEART FAILURE

Due to (or as a consequence of):

b. ARTERIOSCLEROTIC CORONAR VASCULAR DISEASE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Martha E Kern MD

29c. License number

D 44369

29d. Date signed (Month, Day, Year)

DECEMBER 6, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. MARTHA E. KERN, 2 WISCONSIN CIRCLE, CHEVY CHASE, MARYLAND 20815

31. Date filed (Month, Day, Year)

DEC 8 1997

32. Registrar's Signature

*Julia Davidson-Randall*State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Amend #7, 12/11/97, BMW, Montg. Co.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38895

Baltimore, Maryland 21215-0020
 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
 Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,


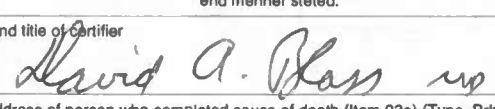
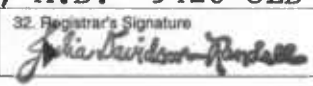
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician /Medical Examiner

Funeral Director

| | | | | | | | | | |
|--|--|---|--|--|--------------------------------|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last) CHARLES WHITE | | | | | | 2. Date of Death Month 12 Day 08 Year 97 | | 3. Time of Death 3:30 PM | |
| 4a. Facility Name (if not institution, give street and number) MARINER HEALTH OF BETHESDA | | | | 4b. City, Town, or Location of Death BETHESDA, MD | | 4c. County of Death MONTGOMERY | | | |
| 5. Social Security Number 286-18-9362 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (in yrs. last birthday) 75 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) 12-15-21 | | 9. Birthplace (State or Foreign Country) OHIO | |
| Usual Residence of Decedent | | | | | | | | | |
| 10a. State MD. | | 10b. County MONTGOMERY | | 10c. City, Town or Location GERMANTOWN | | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10e. Street and Number 12620 RED PEPPER CT. | | | | 10f. Zip Code 20874 | | 10g. Citizen of What Country? U.S.A. | | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever In U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 4 | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) ENGINEER | | | 16b. Kind of Business/Industry PUBLIC UTILITY CO. | | | |
| 17. Father's Name (First, Middle, Last) JAMES WHITE | | | | | | 18. Mother's Name (First, Middle, Maiden Surname) FANNY UNKNOWN | | | |
| 19e. Informant's Name/Relationship (Type, Print) PATTY L. WHITE/DAUGHTER | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SAME AS ITEM #10 | | | | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) CHAMBERS CREMATORY | | Date 12/11/97 | | 20c. Location - City or Town, State RIVERDALE, MD. | | | |
| 21. Signature of Funeral Service Licensee  MO0091 | | | | 22. Name and Address of Facility SILVER SPRING, MD. CHAMBERS FUNERAL HOMES, P.A. 20910 | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) pneumonia Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Alzheimer's dementia Due to (or as a consequence of): Approximate Interval Between Onset and Death days | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Alzheimer's dementia | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of Certifier  David A. Blass M.D. | | | | 29c. License number D23911 | | 29d. Date signed (Month, Day, Year) 12-09-1997 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DAVID A. BLASS, M.D. 9410 OLD GEORGETOWN RD., BETHESDA, MD. 20814 | | | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 11 1997 | | | | 32. Registrar's Signature  | | | | | |

U.S. DEPT. OF JUSTICE

WASHINGTON, D.C.

UNITED STATES OF AMERICA

VS.

JOHN DOE

JOHN DOE

CHARGE OF VIOLATION OF FEDERAL LAWS

IN REPLY TO YOUR LETTER OF JANUARY 15, 1964

RE: [illegible]

YOUR REFERENCE TO THE MATTER OF [illegible]

Very truly yours, [illegible]

97-7020-043

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 38896

DOUGLAS

WELSH Amend #8, 12/8/97, BMW, Montg. Co.

Certificate of Death

Reg. No.

Physician
/Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

| | | | | | | | |
|---|--|---|--|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last) Douglas Brian Welsh | | | | 2. Date of Death Month DECEMBER Day 4 Year 1997 | | 3. Time of Death 3:40 P.M. | |
| 4a. Facility Name (If not institution, give street and number) 18526 HORSE SHOE BEND ROAD | | | | 4b. City, Town, or Location of Death SHARPSBURG | | 4c. County of Death WASHINGTON | |
| 5. Social Security Number 218-66-6310 | | 6. Sex <input type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 43 Yrs. | | 8. Date of Birth (Month, Day, Year) September 14, 1954 | |
| 9. Birthplace (State or Foreign Country) Washington DC | | | | | | | |
| 10a. State MD | | 10b. County Frederick | | 10c. City, Town or Location Frederick | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10e. Street and Number 5702 A Industry Lane | | | | 10f. Zip Code 21701 | | 10g. Citizen of What Country? USA | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 2 | | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Owner/Self Employed | | 16b. Kind of Business/Industry Motorcycle Service and Repair Shop | | | |
| 17. Father's Name (First, Middle, Last) William Joseph Welsh | | | | 18. Mother's Name (First, Middle, Maiden Surname) Winifred Hatfield Smith | | | |
| 19a. Informant's Name/Relationship (Type, Print) Winifred H. Welsh (Mother) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4805 Edgefield Rd. Bethesda, MD 20814 | | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Fort Lincoln Crematory | | Date 12-8-97 | | 20c. Location - City or Town, State Brentwood, MD | |
| 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility Hines-Rinaldi Funeral Home 11800 New Hampshire Ave. Silver Spring, MD 20904 | | | |

| | | | | | |
|---|--|---|--|--|--|
| 23a. Part I. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | 23b. Due to (or as a consequence of): a. Contact Gun shot Wound of Neck b. c. d. Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): | | Approximate Interval Between Onset and Death | |
|---|--|---|--|--|--|

| | | | |
|--|--|--|--|
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | |
| | | 24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| | | 24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |

| | | | | | |
|--|--|---|--|---|--|
| 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) 12/4/97 | | 28b. Time of Injury 2:15 pm M | |
| | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred Subject shot self | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) home | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) 18526 Horse shoe Bend Road Sharpsburg Maryland | |
| 29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier Theodore M. King MD | | 29c. License number O.C.M.E. | |
| | | 29d. Date signed (Month, Day, Year) DECEMBER 5, 1997 | | | |

| | |
|---|-------------------------------|
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) THEODORE M. KING 111 Penn Street, Baltimore, Maryland 21201 | |
| 31. Date filed (Month, Day, Year) DEC 08 1997 | 32. Registrar's Signature |

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transitPhysician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

10

THE UNIVERSITY OF CHICAGO

DEPARTMENT OF CHEMISTRY

LABORATORY OF ORGANIC CHEMISTRY

CHICAGO, ILLINOIS

RECEIVED

1950

RECEIVED

RECEIVED

RECEIVED

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38897

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

Tinn Yee

2. Date of Death

Month Day Year
December 8, 1997

3. Time of Death

1610

4a. Facility Name (If not institution, give street and number)

Suburban Hospital

4b. City, Town, or Location of Death

Bethesda

4c. County of Death

Montgomery

5. Social Security Number

None

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

69 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
August 18, 1928

9. Birthplace (State or Foreign Country)

Pegu, Burma

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

12811 Dean Road

10f. Zip Code

20906

10g. Citizen of What Country?

Burma

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: Asian

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (14 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

U. Sein Hmoon

18. Mother's Name (First, Middle, Maiden Surname)

Daw Thin Mying

19a. Informant's Name/Relationship (Type, Print)

Khin S. Hmoon (sister)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12811 Dean Road, Silver Spring, MD 20906

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Chesapeake Crematory

Date

12-10-97

20c. Location - City or Town, State

Beltsville, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Rapp Funeral Services, P.A.
933 Gist Avenue, Silver Spring, MD 2091023a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a. Coma

1 week

Due to (or as a consequence of):

b. Diabetes Mellitus

20 years

Due to (or as a consequence of):

c. End Stage Renal Disease

1 year

Due to (or as a consequence of):

d. Cerebrovascular Accident

2 years

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Seizure Disorders

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident
3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending
investigation
6 ☐ Could not be
determined28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury at
Work?
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

23091 MD

December 8, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

K. Nossuli, M.D. 4915 Auburn Avenue, Bethesda, MD 20814

31. Date filed (Month, Day, Year)

DEC 11 1997

32. Registrar's Signature

John Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 23a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Amend #30, 12/10/97, BW, Montg. Co. per F.H.M.D.
 Amend #4a,b,10c, 12/10/97, BW, Montg. Co.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38898

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

VIRGINIA JEAN ZELLER

2. Date of Death
Month Day Year

December 3, 1997

3. Time of Death

8:15 A.M.

4a. Facility Name (If not institution, give street and number)

Collington Episcopal Life Care Community, Inc.

4b. City, Town, or Location of Death

Mitchellville

4c. County of Death

Prince Georges

5. Social Security Number

216-38-6182

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

87 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Aug. 27, 1910

9. Birthplace (State or Foreign Country)

Illinois

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince Georges

10c. City, Town or Location

~~Mitchellville~~

Mitchellville

10d. Inside City Limits

= 1 ☐ Yes 2 ☒ No

10e. Street and Number

10450 Lottsford Road

10f. Zip Code

20721

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Teacher

16b. Kind of Business/Industry

Elementary School

17. Father's Name (First, Middle, Last)

Eugene Robert Curtis

18. Mother's Name (First, Middle, Maiden Surname)

Goldie Clime

19a. Informant's Name/Relationship (Type, Print)

Martha Rogerson / Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5200 Edgewood Road, College Park, Maryland 20740

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Fort Lincoln Cemetery

Date

12/6/97

20c. Location - City or Town, State

Brentwood, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Hines-Rinaldi Funeral Home
11800 New Hampshire Avenue
Silver Spring, Maryland 20904

23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a. Cerebrovascular Accident

Due to (or as a consequence of):

b. Hypertension

Due to (or as a consequence of):

c. Atherosclerosis

Due to (or as a consequence of):

d. Mitral Stenosis

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

History of cerebrovascular accidents

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☒ Nursing Home5 ☐ Residence8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending
Investigation6 ☐ Could not be
determined

28a. Date of Injury

(Month, Day Year)

28b. Time of
Injury

M

28c. Injury et
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)
☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

047603

29d. Date signed (Month, Day, Year)

12/03/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

William DuBoys, M.D. 79 Kettering Drive, Upper Marlboro, Maryland 20774

31. Date filed (Month, Day, Year)

DEC 04 1997

32. Registrar's Signature

Julia Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
 Department of Health and Mental Hygiene.
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
 any injury or other traumatic event, the Medical Examiner must be notified at
 once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed
 within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and
 completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1/5/98 Feb

Certificate of Death

Reg. No.

97 38899

Items: 23 part I, 27, 28a-f per MEO G-755

| | | | | | | | | |
|---|--|---|--|--|--|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Pierre Christopher Avery | | | | 2. Date of Death Month Day Year DECEMBER 19, 1997 | | 3. Time of Death 2136PM | |
| | 4a. Facility Name (If not Institution, give street and number) JOHNS HOPKINS HOSPITAL E.R. | | | | 4b. City, Town, or Location of Death BALTIMORE CITY | | 4c. County of Death | |
| Funeral Director | 5. Social Security Number 216-29-4353 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 7 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) 8-19-1990 | 9. Birthplace (State or Foreign Country) Md |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State Md | | 10b. County N/A | | 10c. City, Town or Location Baltimore | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10e. Street and Number 328 Ilchester Avenue | | | | 10f. Zip Code 21218 | | 10g. Citizen of What Country? U SA | | |
| 11. Marital Status <input checked="" type="checkbox"/> Navar Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: Black | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 2nd College (1-4or 5+) N/A | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Student | | | 16b. Kind of Business/Industry N/A | |
| 17. Father's Name (First, Middle, Last) Henry Avery | | | | 18. Mother's Name (First, Middle, Maiden Surname) Barbara Butler | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Barbara Butler- Mother | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 521 Belnord Avenue Baltimore, Md 21205 | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) King Memorial Park | | Date 12-24-97 | | 20c. Location - City or Town, State Randallstown, Md |
| 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility March F/H West 4300 Wabash Avenue Baltimore, Md 21215 | | | | |
| 23a. Pertinent disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. SMOKE INHALATION Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | | | | | | | Approximate Interval Between Onset and Death |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) 12/19/97 | | 28b. Time of Injury P. M | | 28c. Injury et Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred House Fire |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Home | | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) 328 Ilchester Ave. Baltimore City, Md. | |
| 29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier | | 29c. License number O.C.M.E. | | 29d. Date signed (Month, Day, Year) DECEMBER 20, 1997 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 24 1997 | | 32. Registrar's Signature | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38900

| | | | | | | | | |
|--|--|--|---|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) ROSA L. BOYD | | | | 2. Date of Death Month Day Year Dec 23 1997 | | 3. Time of Death 9:51 am | |
| | 4a. Facility Name (If not institution, give street and number) HOWARD COUNTY GENERAL HOSPITAL | | | | 4b. City, Town, or Location of Death COLUMBIA | | 4c. County of Death HOWARD | |
| Funeral Director | 5. Social Security Number 248-36-0996 | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 10 Yrs. | 8. Date of Birth (Month, Day, Year) 4-12-27 | 9. Birthplace (State or Foreign Country) SC | | | |
| | Usual Residence of Decedent | | | | | | | |
| To Be Completed by Funeral Director | 10a. State NY | 10b. County NASSAU | 10c. City, Town or Location N/A | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| | 10e. Street and Number 5 CASSEL COURT | | 10f. Zip Code 11590 | | 10g. Citizen of What Country? USA | | | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: BLACK | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8TH GRADE College (1-4 or 5+) N/A | | 15a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOUSE KEEPING | | 15b. Kind of Business/Industry HOWARD JOHNSON | | | |
| | 17. Father's Name (First, Middle, Last) WILLIAM ALLEN | | | | 18. Mother's Name (First, Middle, Maiden Surname) LOUISE O'BANNOR | | | |
| Physician /Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) SYLVIA BOYD | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5 CASSEL COURT, NASSAU, NY 11590 | | | | | |
| | 20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) PLAINLAWN CEMETERY | | 20c. Date 12-27-97 | | 20d. Location - City or Town, State HICKVILLE, NY | |
| | 21. Signature of Funeral Service Licensee Vaughn C. Greene | | 22. Name and Address of Facility VAUGHN C. GREENE FUNERAL SER. 5151 BALTO. NAT'L PIKE, BALTO. MD. 21229 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. MYOCARDIAL INFARCTION Due to (or as a consequence of): b. HYPERTENSION Due to (or as a consequence of): c. Due to (or as a consequence of): d. Approximate Interval Between Onset and Death 4 hours many years | | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) | | | | | |
| | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | | | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | |
| | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| | 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| State Registrar | 29b. Signature and title of certifier Howard J. Morris | | 29c. License number D41320 | | 29d. Date signed (Month, Day, Year) Dec 24, 1997 | | | |
| | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) HOWARD J. MORRIS, M.D. Howard County General Hosp. 5755 Cedar Lane Columbia MD 21044 | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 24 1997 | | 32. Registrar's Signature John Davidson-Randall | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **97 38901**
Certificate of Death

Item#17perFHG754 12/24/97 EW

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Geraldine Bevans

2. Date of Death

Month Day Year
DECEMBER 18, 1997

3. Time of Death

12:21 PM

4a. Facility Name (If not institution, give street and number)

JOHNS HOPKINS HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE CITY

4c. County of Death

BALTIMORE

5. Social Security Number

219-22-8199

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

72 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
10-12-1925

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

NA

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

820 Argonne Drive

10f. Zip Code

21218

10g. Citizen of What Country?

U.S.A

11. Marital Status

1 ☒ Never Married 2 ☐ Married
 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
 If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

11th grade

College (1-4 or 5+)

NA

16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

House Keeping

16b. Kind of Business/Industry

Hotel

17. Father's Name (First, Middle, Last)

Helen Bevans

William Bevans

18. Mother's Name (First, Middle, Maiden Surname)

Helen Garrett

19e. Informant's Name/Relationship (Type, Print)

Helen Bevans - Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

820 Argonne Drive Baltimore, MD 21218

20e. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

MT Zion Cemetery

Date

12-26-97

20c. Location - City or Town, State

Lansdown, MD

21. Signature of Funeral Service Licensee

Gabrielle Cort

22. Name and Address of Facility

March Fitt West 21215
 4300 Wabash Avenue Baltimore, MD

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Sepsis

Due to (or as a consequence of):

b. End Stage Renal Disease

Due to (or as a consequence of):

c. _____

Due to (or as a consequence of):

d. _____

Approximate Interval Between Onset and Death

3 days

1 year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Cerebral vascular accident

Hypertension

Hypothyroidism

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24e. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
 5 ☐ Pending Investigation 6 ☐ Could not be determined

28e. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Karen Wendel MD

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

December 18, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Karen Wendel Johns Hopkins Hospital Baltimore Maryland

31. Date filed (Month, Day, Year)

DEC 24 1997

32. Registrar's Signature

[Signature]

State Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38902

Item#20b per FH G754 12/24/97 EW

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

EBONY BAKER

2. Date of Death

Month DEC Day 21 Year 1997

3. Time of Death

0650 HRS

4a. Facility Name (If not institution, give street and number)

MOUNT WASHINGTON PEDIATRIC HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE CITY

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

213-49-0993

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

Yrs. 1

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year) DEC 9, 1990

9. Birthplace (State or Foreign Country)

BALTIMORE CITY

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

BALTIMORE CITY

10c. City, Town or Location

BALTIMORE CITY

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2436 EAST CHASE STREET

10f. Zip Code

MARYLAND 21213

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12) N/A

College (14 or 5+) N/A

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

N/A

16b. Kind of Business/Industry

N/A.

17. Father's Name (First, Middle, Last)

WILLIAM BAKER

18. Mother's Name (First, Middle, Maiden Surname)

LISA KATHERINE BROWN

19a. Informant's Name/Relationship (Type, Print)

LISA BROWN / MOTHER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2436 EAST CHASE STREET, BALTIMORE, MARYLAND 21213

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of Mt. Zion cemetery, crematory or other place)

BEST FUNERAL HOME

Data

12/30/97

20c. Location - City or Town, State

BALTIMORE CITY

21. Signature of Funeral Service Licensee

Patricia Beets

22. Name and Address of Facility

Beth's Funeral Home
1129 N Caroline St Balto, MD 21212

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

CEREBRAL EDEMA

Due to (or as a consequence of):

b.

RHABDOMYOSARCOMA

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

N/A

28b. Time of Injury

N/A M

28c. Injury et Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

N/A

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

N/A

28f. Location (Street and Number or Rural Route Number, City or Town, State)

N/A.

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Ahmet Aybar, MD

29c. License number

MARYLAND D48164

29d. Date signed (Month, Day, Year)

DEC 21, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AHMET AYBAR, MD.
1708 WEST ROGERS AVENUE, BALTIMORE, MARYLAND 21209

31. Date filed (Month, Day, Year)

DEC 24 1997

32. Registrar's Signature

Julia Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1111 W. Carline St
2151044, 01 02

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38903

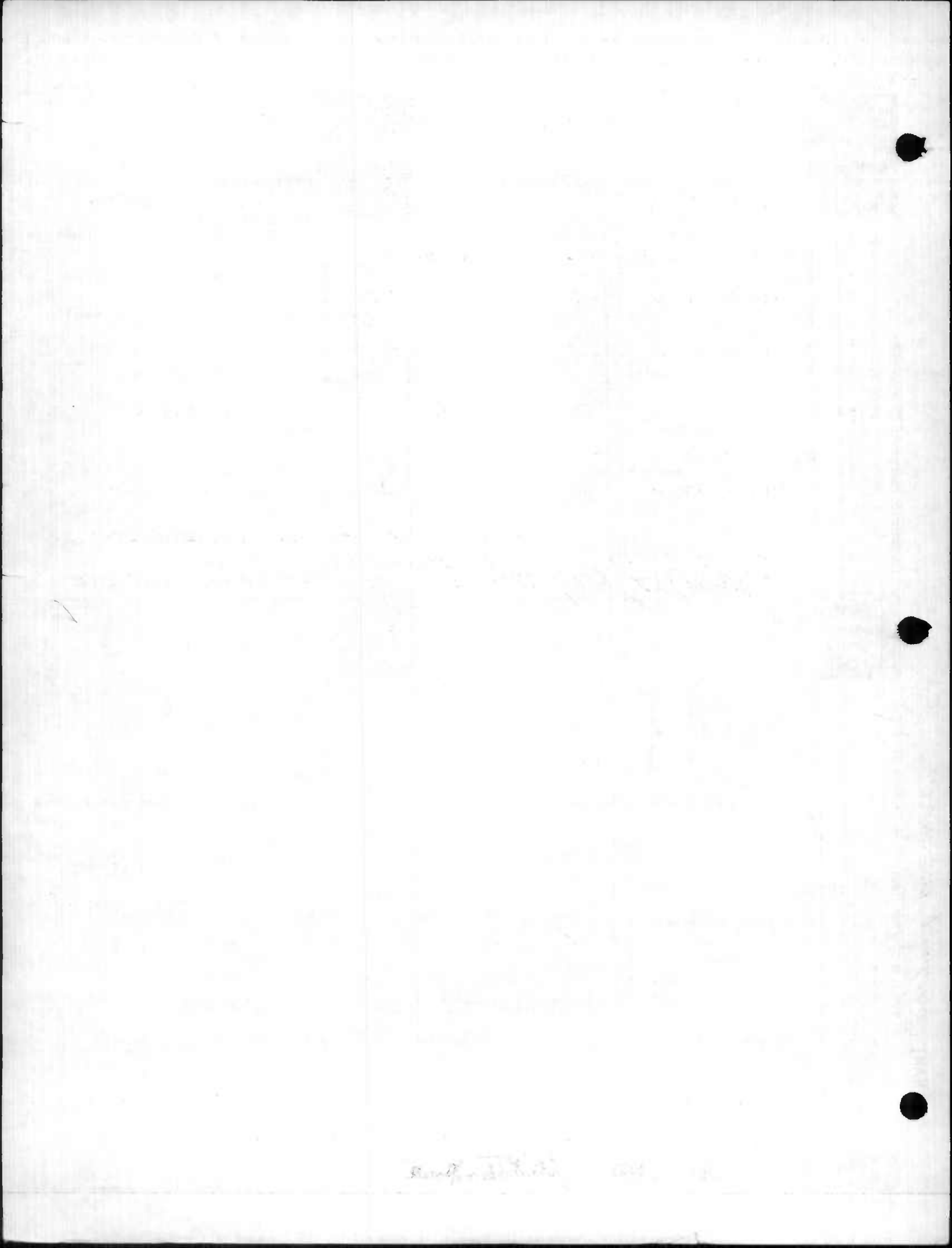
| | | | | | | | | |
|--|--|--|---|-----------------------------------|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Vernon William Buppert | | | | 2. Date of Death Month: Dec. Day: 17 Year: 1997 | | 3. Time of Death 12:25 A.M. | |
| | 4a. Facility Name (If not institution, give street and number) ST. AGNES HOSP. | | | | 4b. City, Town, or Location of Death BALTIMORE | | 4c. County of Death N/A | |
| Funeral Director | 5. Social Security Number 212-03-4657 | | 6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 88 Yrs. | | 8. Date of Birth (Month, Day, Year) Nov. 19, 1909 | |
| | Usual Residence of Decedent | | 9. Birthplace (State or Foreign Country) Maryland | | 10. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| To Be Completed by Funeral Director | 10a. State Maryland | | 10b. County Baltimore Co. | | 10c. City, Town or Location Catonsville | | | |
| | 10e. Street and Number 801 Winters Lane # 446 | | | | 10f. Zip Code 21228 | | 10g. Citizen of What Country? U.S.A. | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Plumber | | 16b. Kind of Business/Industry Jas.W.Keatts & Bros. | | | |
| | 17. Father's Name (First, Middle, Last) William L. Buppert | | | | 18. Mother's Name (First, Middle, Maiden Surname) Marie M. Mack | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Janis L. Phelps Daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5538 Carville Ave. Arbutus, Maryland 21227 | | | |
| | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Mt.Olive U.M.C.Cemetery | | Date Dec.20,1997 | | 20c. Location - City or Town, State Randallstown,Md. | |
| | 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility McCully-Polyniak Funeral Home 3204 Mountain Road Pasadena, Maryland 21122 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. CEREBROVASCULAR ACCIDENT Due to (or as a consequence of): b. PNEUMONIA Due to (or as a consequence of): c. UROSEPSIS Due to (or as a consequence of): d. SEPTICEMIA | | | | | | | |
| | 23b. Approximate Interval Between Onset and Death 6 months 2 weeks 2 weeks 2 days | | | | | | | |
| Physician /Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | |
| | | | | | | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| | 25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28d. Describe how Injury occurred | | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier M.D. | | 29c. License number P11701 | | 29d. Date signed (Month, Day, Year) Dec. 17, 1997 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. F. NICULESCU ST. AGNES HOSP. | | | | | | | | |
| State Registrar | 31. Date filed (Month, Day, Year) DEC 24 1997 | | | | 32. Registrar's Signature | | | |

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

NAME: Buppert, Vernon W.
To the Hospital or Attending Physician: The law requires that the death certificate be completed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38904

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ANN G. BOYD

2. Date of Death

Month Day Year
DECEMBER 19, 1997

3. Time of Death

10:45 AM

4a. Facility Name (If not Institution, give street and number)

16412 KIPLING ROAD

4b. City, Town, or Location of Death

ROCKVILLE

4c. County of Death

MONTGOMERY

5. Social Security Number

214 12 9316

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

93

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
AUG. 21, 1904

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD.

10b. County

MONTGOMERY

10c. City, Town or Location

SILVER SPRING

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1108 EDNOR ROAD

10f. Zip Code

20905

10g. Citizen of What Country?

UNITED STATES

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

WHITE

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation
(Give kind of work done during most of working

life. DO NOT use retired)

SCHOOL TEACHER

16b. Kind of Business/Industry

EDUCATION

17. Father's Name (First, Middle, Last)

CLARENCE L. GILPIN

18. Mother's Name (First, Middle, Maiden Surname)

ROSE STABLER

19a. Informant's Name/Relationship (Type, Print)

F. LEA GILPIN, NEPHEW

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1108 EDNOR ROAD, SILVER SPRING, MD. 20905

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

METROPOLITAN CREMATORY

Date

12/20/97

20c. Location - City or Town, State

ALEXANDRIA, VA.

21. Signature of Funeral Service Licensee

Muriel H. Barber

22. Name and Address of Facility

MURIEL H. BARBER FUNERAL HOME

P.O. BOX 5038, LAYTONSVILLE, MD. 20882

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

MYOCARDIAL INFARCTION

Approximate Interval Between Onset and Death

1 DAY

e. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ALZHEIMERS DEMENTIA

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

James Michael Anchors

29c. License number

DZ9730

29d. Date signed (Month, Day, Year)

DECEMBER 19, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

James Michael Anchors 16220 Frederick Rd Gaithersburg Md 20877

31. Date filed (Month, Day, Year)

DEC 24 1997

32. Registrar's Signature

Julia Davidson-Rendall

State
Registrar

ANN BOYD

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "Natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

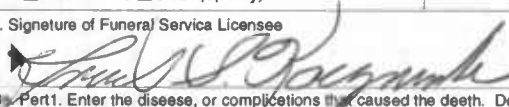
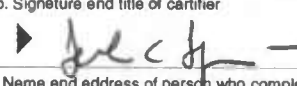
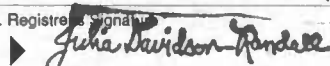
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38905

| | | | | | | | | |
|---|--|--|---|--------------------------------|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Hilda M. Christopher | | | | 2. Date of Death Month Day Year Dec. 20, 1997 | | 3. Time of Death 11:20 p.m. | |
| | 4a. Facility Name (If not institution, give street and number) Corsica Hills Nursing Home | | | | 4b. City, Town, or Location of Death Centerville | | 4c. County of Death Queen Anne | |
| Funeral Director | 5. Social Security Number 219-38-8213 | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 92 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) July 4, 1905 | 9. Birthplace (State or Foreign Country) Maryland | |
| | Usual Residence of Decedent | | | | | | | |
| To Be Completed by Funeral Director | 10a. State Maryland | 10b. County Anne Arundel | 10c. City, Town or Location Pasadena | | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| | 10e. Street and Number 774 223rd Street | | | 10f. Zip Code 21122 | | 10g. Citizen of What Country? U.S.A. | | |
| To Be Completed by Physician/Medical Examiner | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4 or 5+) N/A | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker | | 16b. Kind of Business/Industry Own Home | | | |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last) Edgar Keefer Hynes | | | | 18. Mother's Name (First, Middle, Maiden Surname) Emma Mitzel | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Charles Christopher Son | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 774 223rd Street Pasadena, Maryland 21122 | | | |
| To Be Completed by Physician/Medical Examiner | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Glen Haven Mem. Park | | Date Dec. 23, 1997 | | 20c. Location - City or Town, State Glen Burnie, Maryland | |
| | 21. Signature of Funeral Service Licensee  | | 22. Name and Address of Facility McCully-Polyniak Funeral Home 3204 Mountain Road Pasadena, Maryland 21122 | | | | | |
| To Be Completed by Physician/Medical Examiner | 23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. CVA Due to (or as a consequence of): Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. ASCVD Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | | | | | | Approximate Interval Between Onset and Death |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | |
| | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 28. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) | | | | | |
| | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 8 <input type="checkbox"/> Could not be determined | | 28e. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| To Be Completed by Physician/Medical Examiner | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28d. Describe how Injury occurred | | | | | |
| | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 28g. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| | 29b. Signature and title of certifier  | | | | 29c. License number D-13824 | | 29d. Date signed (Month, Day, Year) 12-22-97 | |
| To Be Completed by Physician/Medical Examiner | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Helen Noble, M.D., 122 Speer Road Chestertown, Maryland 21620 | | | | | | | |
| | 31. Date filed (Month, Day, Year) DEC 24 1997 | | | | 32. Registrar's Signature  | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38906

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ELLA K. COOPER

2. Date of Death

December 20th 1997 8:55 pm

3. Time of Death

Funeral
Director

4e. Facility Name (If not institution, give street and number)

HARBOR HOSPITAL CENTER

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

5. Social Security Number

214-01-2561

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

87 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Mar. 22, 1910

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10e. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

103 Fifth Ave

10f. Zip Code

21225

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.Specify:
White15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
5thCollege (1-4or 5+)
N/A16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Alexander

Liszczyńska

18. Mother's Name (First, Middle, Maiden Surname)

Magdalene

Wojtowicz

19a. Informant's Name/Relationship (Type, Print)

William A. Cooper (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

103 Fifth Ave Baltimore, Maryland 21225

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Holy Cross Cemetery

Date

Dec. 24
1997

20c. Location - City or Town, State

Brooklyn Park, Md.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

McCully-Polyniak Funeral Home

237 E. Patapsco Ave Baltimore, Md. 21225

23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. CONGESTIVE HEART FAILURE

two days

Due to (or as a consequence of):

b. ATRIAL FAILURE

6 years

Due to (or as a consequence of):

c. Hypertensive ARTERIO-SCLEROTIC DISEASE 6 years

Due to (or as a consequence of):

Sequently list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DIABETES MELLITUS

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

29c. License number

AS 2441614-16

29d. Date signed (Month, Day, Year)

DECEMBER 20th 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

K. AMBALAVANAR HARBOR HOSPITAL CENTER, SOUTH HANOVER STREET BALTIMORE

31. Date filed (Month, Day, Year)

DEC. 9 1997

32. Registrar's Signature

Theresa Davidson

State
Registrar

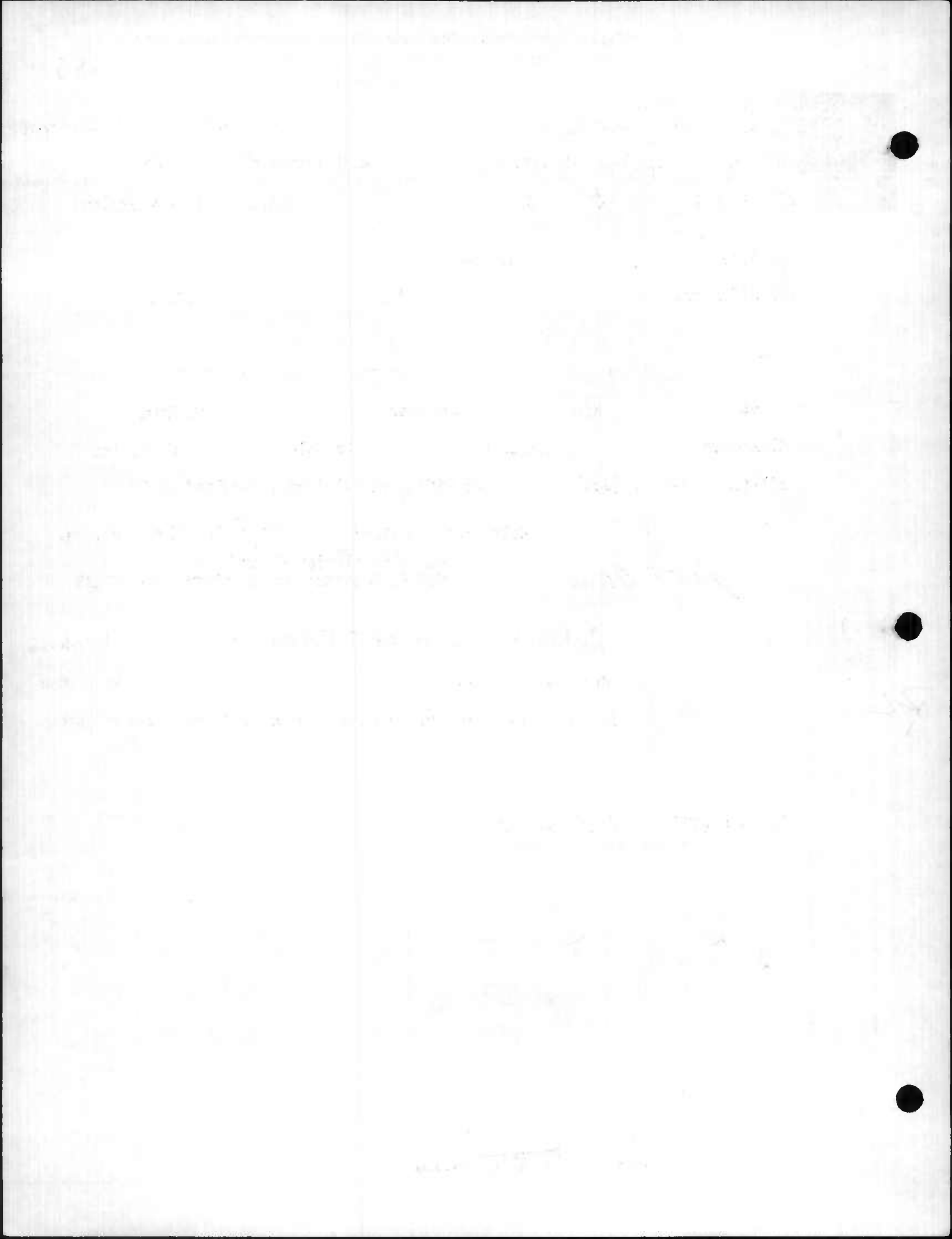
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23e-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit
certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



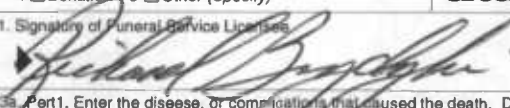
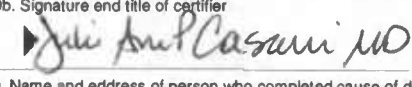

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38907

| | | | | | | | | |
|---|--|---|---|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Charles Leonard CARNES | | | | 2. Date of Death Month December Day 22 , Year 1997 | | 3. Time of Death 9:40 am | |
| | 4e. Facility Name (If not institution, give street and number) Franklin Square Hospital Center | | | | 4b. City, Town, or Location of Death Rosedale | | 4c. County of Death Baltimore | |
| Funeral Director | 5. Social Security Number 212-26-4092 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 68 Yrs. | | 8. Date of Birth (Month, Day, Year) Jan. 5, 1929 | |
| | 9. Birthplace (State or Foreign Country) Maryland | | 10a. State Maryland | | 10b. County Baltimore | | 10c. City, Town or Location Middle River | |
| To Be Completed by Funeral Director | Usual Residence of Decedent | | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| | 10e. Street and Number 6800 Leslie Road | | | | 10f. Zip Code 21220 | | 10g. Citizen of What Country? U.S.A. | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Masonry Foreman | | 16b. Kind of Business/Industry Construction | | | |
| | 17. Father's Name (First, Middle, Last) Charles Leonard Carnes, Sr. | | | | 18. Mother's Name (First, Middle, Maiden Surname) Beulah M. Hare | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Carolyn Carnes (WIFE) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6800 Leslie Road Middle River, Md. 21220 | | | |
| | 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Greenmount Crematory | | 20c. Location - City or Town, State 12/24/1997 Baltimore, Md. | | | |
| | 21. Signature of Funeral Service Licensee  | | | | 22. Name and Address of Facility Bruzdziński Funeral Home P.A. 1407 Old Eastern Avenue Essex, Md. 21221 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last e. Congestive Heart Failure Due to (or as a consequence of): b. Atherosclerotic Cardiovascular Disease Due to (or as a consequence of): c. Due to (or as a consequence of): d. Approximate Interval Between Onset and Death 2 Years | | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Squamous Cell Lung Cancer- Remission | | | | | | 23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 28d. Describe how Injury occurred | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier  Julie Casani M.D. | | | | 29c. License number D28214 | | 29d. Date signed (Month, Day, Year) December 22, 1997 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Julie Casani M.D. 9000 Franklin Square Drive Baltimore, Maryland 21237 | | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 24 1997 | | 32. Registrar's Signature  | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be secured within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 38908

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

TA MING, CHANG

2. Date of Death

DEC.

20, 1997

3. Time of Death

6:34 PM

4e. Facility Name (If not institution, give street and number)

Saint Joseph Medical Center

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

5. Social Security Number

214-80-6552

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

85 Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

Jan. 18, 1912

9. Birthplace (State or Foreign Country)

China

Usual Residence of Decedent

10e. State

NY

10b. County

Queens

10c. City, Town or Location

Woodside

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

41-44 70th Street

10f. Zip Code

11377

10g. Citizen of What Country?

United States

11. Marital Status

☐ Never Married ☒ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
☐ Yes ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Asian

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
6

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Accountant

16b. Kind of Business/Industry

Restaurant

17. Father's Name (First, Middle, Last)

(Unknown) Chang

18. Mother's Name (First, Middle, Maiden Surname)

(Unknown)

19a. Informant's Name/Relationship (Type, Print)

Hang Sang Cheung/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

58 - 48 41st Drive, Woodside, NY 11377

20e. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Green Mount Crematory

Date

12-24-97

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

CAFA - Stephen D. Lohrmann, P.A.

8717 Green Pastures Drive, Baltimore, MD 21286

23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. ASPIRATION

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CHRONIC OBSTRUCTIVE LUNG DISEASE

COR PULMONALE

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☐ Probably ☒ Unknown

24e. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☒ Inpatient☐ ER/Outpatient☐ DOA

Other:

☐ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending Investigation
☐ Accident ☐ Could not be determined
☐ Suicide ☐ Homicide

28e. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D37254

29d. Date signed (Month, Day, Year)

12-21-97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

BOON P. LIM, M.D., 7620 YORK ROAD, TOWSON, MARYLAND 21204

31. Date filed (Month, Day, Year)

DEC 24 1997

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68768

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38909

| | | | | | | | | |
|--|---|---|---|--|--|--|---|---|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) <u>Lillian Early</u> | | | | 2. Date of Death Month <u>December</u> Day <u>17</u> Year <u>1997</u> | | 3. Time of Death <u>11:40am</u> | |
| | 4a. Facility Name (If not institution, give street and number) <u>BAYVIEW MEDICAL CENTER</u> | | | | 4b. City, Town, or Location of Death <u>BALTO</u> | | 4c. County of Death <u>N/A</u> | |
| Funeral Director | 5. Social Security Number <u>218-22-9121</u> | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) <u>78</u> Yrs. | If Under 1 Year Months | If Under 24 Hrs. Hours | 8. Date of Birth (Month, Day, Year) <u>AUG 16, 1919</u> | 9. Birthplace (State or Foreign Country) <u>MD</u> |
| | Usual Residence of Decedent | | | | | | | |
| To Be Completed by Funeral Director | 10a. State <u>MD</u> | 10b. County <u>N/A</u> | 10c. City, Town or Location <u>BALTO</u> | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | 10e. Street and Number <u>202 N. LINWOOD AVE</u> | | | | 10f. Zip Code <u>21224</u> | | 10g. Citizen of What Country? <u>U.S.A.</u> | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: <u>BLACK</u> | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12th</u> | | 15a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>HOUSEKEEPER</u> | | 15b. Kind of Business/Industry <u>NURSING HOME</u> | | | |
| | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>HOUSEKEEPER</u> | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>HOUSEKEEPER</u> | | 16b. Kind of Business/Industry <u>NURSING HOME</u> | | | |
| | 17. Father's Name (First, Middle, Last) <u>Unknown</u> | | | | 18. Mother's Name (First, Middle, Maiden Surname) <u>Unknown</u> | | | |
| | 19a. Informant's Name/Relationship (Type, Print) <u>BOYD EARLY/SON</u> | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>202 N. LINWOOD AVE BALTO, MD 21224</u> | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) <u>GARRISON FOREST VACEM</u> | | 20c. Location - City or Town, State <u>OWINGS MILLS, MD</u> | | | |
| | 21. Signature of Funeral Service Licensee <u>Patricia Betts</u> | | | | 22. Name and Address of Facility <u>BETTS FUNERAL HOME</u> <u>1129 N CAROLINE ST BALTO, MD 21213</u> | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>sepsis</u> Due to (or as a consequence of): b. <u>decubitus ulcers</u> Due to (or as a consequence of): c. <u>myocardial infarction</u> Due to (or as a consequence of): d. Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>multiple CVA's, DM, HTN, CHF</u> | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28d. Describe how injury occurred | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier <u>Lisa Seyfried MD</u> | | 29c. License number <u>RES-000</u> | | 29d. Date signed (Month, Day, Year) <u>December 17, 1997</u> | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>Lisa Seyfried MD Johns Hopkins Bayview Medical Center Baltimore, MD 21224</u> | | | | | | | | |
| 31. Date filed (Month, Day, Year) <u>DEC 24 1997</u> | | 32. Registrar's Signature <u>Julia Davidson-Randall</u> | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38910

| | | | | | | | | |
|--|---|--|---|--|--|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) HADEL ETHEREDGE | | | | 2. Date of Death Month Day Year DECEMBER 19, 1997 | | 3. Time of Death 6:30 a | |
| | 4e. Facility Name (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL | | | | 4b. City, Town, or Location of Death BALTIMORE CITY | | 4c. County of Death N/A | |
| Funeral Director | 5. Social Security Number 38-70-8484 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 52 Yrs. | | 8. Date of Birth (Month, Day, Year) APRIL 5, 1945 | |
| | 9. Birthplace (State or Foreign Country) SC | | 10a. State MD | | 10b. County N/A | | 10c. City, Town or Location BALTO | |
| To Be Completed by Funeral Director | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number 1731 N BOND ST | | 10f. Zip Code 21213 | | 10g. Citizen of What Country? U.S.A. | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: BLACK | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11th College (1-4 or 5+) N/A | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) CUSTODIAN | | 16b. Kind of Business/Industry MARKET | | | |
| | 17. Father's Name (First, Middle, Last) WILBERT ETHEREDGE | | | | 18. Mother's Name (First, Middle, Maiden Surname) ANNIE DOZIER | | | |
| | 19a. Informant's Name/Relationship (Type, Print) ELLEN ETHEREDGE | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1731 N BOND ST BALTO, , MD 21213 | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) MT. ZION CEM | | 20c. Location - City or Town, State BALTO, MD | | 20d. Date DEC 23 1997 | |
| | 21. Signature of Funeral Service Licensee  | | | | 22. Name and Address of Facility BETTS FUNERAL HOME 1129 N. CAROLINE ST BALTO, MD 21213 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. metastatic cancer Due to (or as a consequence of): b. history of squamous cell cancer of head and neck Due to (or as a consequence of): c. Due to (or as a consequence of): d. Approximate Interval Between Onset and Death 1 week 5 months | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | |
| | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. hypercalcemia aspiration pneumonia | | | | | | | |
| | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| State Registrar | 29b. Signature and title of certifier  HOUSE STAFF | | | | 29c. License number RES-000 | | 29d. Date signed (Month, Day, Year) DECEMBER 19, 1997 | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BRIAN LEE, JOHNS HOPKINS HOSPITAL 600 NORTH WOLFE STREET BALTIMORE | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 24 1997 | | 32. Registrar's Signature  | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38911

Physician
/Medical
Examiner

Funeral
Director

1. Decedent's Name (First, Middle, Last)

LILLIAN EDER

2. Date of Death
Month Day Year
DECEMBER 18 1997

3. Time of Death
12:42 P.M.

4a. Facility Name (If not institution, give street and number)

HARBOR HOSPITAL CENTER

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

BALTIMORE

5. Social Security Number

217-03-2889

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

79 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Jan. 29 1918

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

Md.

10b. County

n/a

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

126 W. Clement Street

10f. Zip Code

21230

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12

College (1-4 or 5+)
0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Clerical

16b. Kind of Business/Industry

Poland Brothers

17. Father's Name (First, Middle, Last)

John Henry

18. Mother's Name (First, Middle, Maiden Surname)

Lillian M. Smith

19a. Informant's Name/Relationship (Type, Print)

Dennis Eder (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7312 Kirtley Road Baltimore, Md. 21224

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Cedar Hill Cemetery

Date

Dec. 22 1997

20c. Location - City or Town, State

Brooklyn Park, Md.

21. Signature of Funeral Service Licensee

Daniel A. Taylor

22. Name and Address of Facility

McCully-Polyniak Funeral Home

130 E. Fort Ave. Baltimore, Md. 21230

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. END STAGE BREAST CANCER

Approximate Interval Between Onset and Death

12 MONTHS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

HYPERTENSIVE ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE

CONGESTIVE HEART FAILURE

CHRONIC OBSTRUCTIVE PULMONARY DISEASE

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home

5 ☐ Residence

6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Anita Nahar, RESIDENT, HOUSE STAFF

29c. License number

AS 2441614-45

29d. Date signed (Month, Day, Year)

DECEMBER, 18, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

ANITA NAHAR, 3001 SOUTH HANOVER STREET, BALTIMORE, MD 21225

31. Date filed (Month, Day, Year)

DEC 24 1997

32. Registrar

John Davidson-Randall

State
Registrar

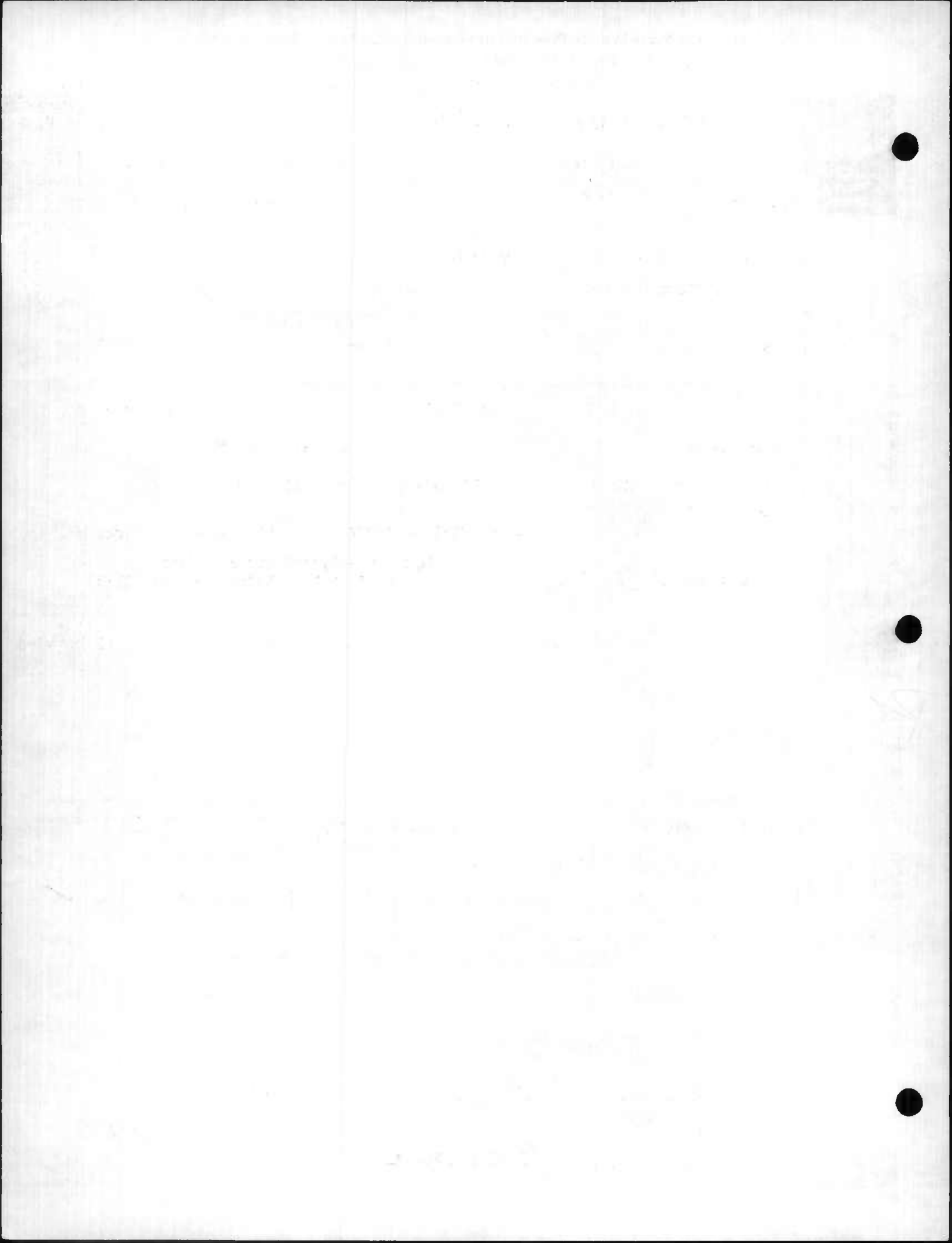
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760

permitted. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38912

| | | | | | | | | |
|---|--|---|---|---|--|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) DURUTH EITEMILLER | | | | 2. Date of Death Month December Day 23 Year 1997 | | 3. Time of Death 3:42 PM | |
| | 4a. Facility Name (If not institution, give street and number) CHURCH HOME HOSPITAL | | | | 4b. City, Town, or Location of Death BALTIMORE | | 4c. County of Death N/A | |
| Funeral Director | 5. Social Security Number 213106349 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 90 Yrs. | | 8. Date of Birth (Month, Day, Year) OCT. 28, 1907 | |
| | 9. Birthplace (State or Foreign Country) MARYLAND | | 10a. State MD | | 10b. County N/A | | 10c. City, Town or Location BALTIMORE | |
| To Be Completed by Funeral Director | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number 5306 PLYMOUTH ROAD | | 10f. Zip Code 21214 | | 10g. Citizen of What Country? USA | |
| | 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) 0 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) ASSEMBLY | | 16b. Kind of Business/Industry SHADE BLINDS | | | |
| | 17. Father's Name (First, Middle, Last) CHARLES EITEMILLER | | | | 18. Mother's Name (First, Middle, Maiden Surname) MARY UNK. | | | |
| | 19a. Informant's Name/Relationship (Type, Print) PATRICIA EITEMILLER/ NIECE | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5306 PLYMOUTH RD BALTIMORE, MD 21214 | | | |
| | 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) METRO CREMATORY | | Date 12/24 | | 20c. Location - City or Town, State BALTIMORE, MD | |
| | 21. Signature of Funeral Service Licensee | | 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 1211 CHESACO AVE BALTO, MD 21237 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| | 23b. Approximate Interval Between Onset and Death 1 MONTH | | | | | | | |
| | 23c. Immediate Cause (Final disease or condition resulting in death) a. CONGESTIVE HEART FAILURE Due to (or as a consequence of): b. ARTERIOVENOUS UNBALANCED DISORDERS Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. URINARY TRACT INFECTION DEMENTIA | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 28d. Describe how injury occurred | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier | | 29c. License number 015135 | | 29d. Date signed (Month, Day, Year) December 23, 1997 | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NEWELL R SWITH MD 100 N. BROADWAY BALTIMORE, MD 21237 | | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 24 1997 | | 32. Registrar's Signature | | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38913

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

George Rudolph Fowler

2. Date of Death

December 20, 1997 5:53 am

3. Time of Death

Funeral
Director

4a. Facility Name (If not institution, give street and number)

NORTH ARUNDEL HOSPITAL

4b. City, Town, or Location of Death

Glen Burnie

4c. County of Death

Anne Arundel

5. Social Security Number

214-20-3048

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

71 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

Sept. 10, 1926 Maryland

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD.

10b. County

Anne Arundel

10c. City, Town or Location

Pasadena

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8437 Rugby Road

10f. Zip Code

21122

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married

3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8th

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Heavy Equipment Operator

16b. Kind of Business/Industry

City Of Baltimore

17. Father's Name (First, Middle, Last)

John Edgar Fowler

18. Mother's Name (First, Middle, Maiden Surname)

Annie Rebecca Thompson

19a. Informant's Name/Relationship (Type, Print)

Georgia Brackett (Daughter) 8437 Rugby Road Pasadena, Maryland 21122

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Cedar Hill Cemetery

Date

12/26/97

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

[Signature]

Kevin E. Ecker

22. Name and Address of Facility

McCully-Polyniak Funeral Homes

237 E. Patapsco Avenue Balto., MD. 21225

23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Congestive Heart Failure

Approximate Interval Between Onset and Death

1 Day

e. Due to (or as a consequence of):

Coronary Artery Disease

2 Year

b. Due to (or as a consequence of):

Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Previous Myocardial Infarction

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☒ Outpatient

3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation

2 ☐ Accident

3 ☐ Suicide

4 ☐ Homicide

6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Whymore, M.D. Attending Doctor

29c. License number

D21684

29d. Date signed (Month, Day, Year)

12-23-97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

CY-CYRIAC-M.D 8109 RITCHIE HWY, PASADENA, MD 21122

31. Date filed (Month, Day, Year)

DEC 24 1997

32. Registrar's Signature

Julia Davidson-Randall

State
Registrar

FOWLER GEORGE
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be completed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

10

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38914

Physician
/Medical
Examiner

Funeral
Director

| | | | | | | | | |
|--|--|---|--|---|---|--|---|--|
| 1. Decedent's Name (First, Middle, Last) JANICE MARIE FISHER | | | | 2. Date of Death Month: DECEMBER Day: 23 Year: 1997 | | 3. Time of Death 1:30 pm | | |
| 4a. Facility Name (If not institution, give street and number) 6709 HAVENOAK ROAD APT B-2 | | | | 4b. City, Town, or Location of Death ROSEDALE | | 4c. County of Death BALTIMORE | | |
| 5. Social Security Number 213584694 | | 6. Sex 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 47 Yrs. | If Under 1 Year Months: Days: Hours: Min. | 8. Date of Birth (Month, Day, Year) SEPT 29, 1950 | | 9. Birthplace (State or Foreign Country) MARYLAND | |
| Usual Residence of Decedent | | | | | | | | |
| 10a. State MD | | 10b. County BALTIMORE | | 10c. City, Town or Location ROSEDALE | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| 10e. Street and Number 6709 HAVENOAK ROAD APT B2 | | | | 10f. Zip Code 21237 | | 10g. Citizen of What Country? USA | | |
| 11. Marital Status 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12): 12 College (1-4 or 5+): 0 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER | | 16b. Kind of Business/Industry OWN HOME | | |
| 17. Father's Name (First, Middle, Last) WILLIAM BOLD | | | | 18. Mother's Name (First, Middle, Maiden Surname) CATHERINE SECERT | | | | |
| 19a. Informant's Name/Relationship (Type, Print) JOHN M. FISHER / HUSBAND | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6709 HAVENOAK ROAD ROSEDALE, MD 21237 (Apt B2) | | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify): | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) GARDENS OF FAITH | | 20c. Location - City or Town, State 12/27 BALTIMORE, MD | | |
| 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 1211 CHESACO AVE BALTO, MD 21237 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Respiratory Failure Due to (or as a consequence of): b. Lung Cancer Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | |
| Approximate Interval Between Onset and Death minutes 2 years | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| | | 28d. Describe how injury occurred | | | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier | | 29c. License number 044944 | | 29d. Date signed (Month, Day, Year) 12/24/97 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stan Walker Union Memorial Hospital Baltimore MD 21218 | | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 24 1997 | | 32. Registrar's Signature | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

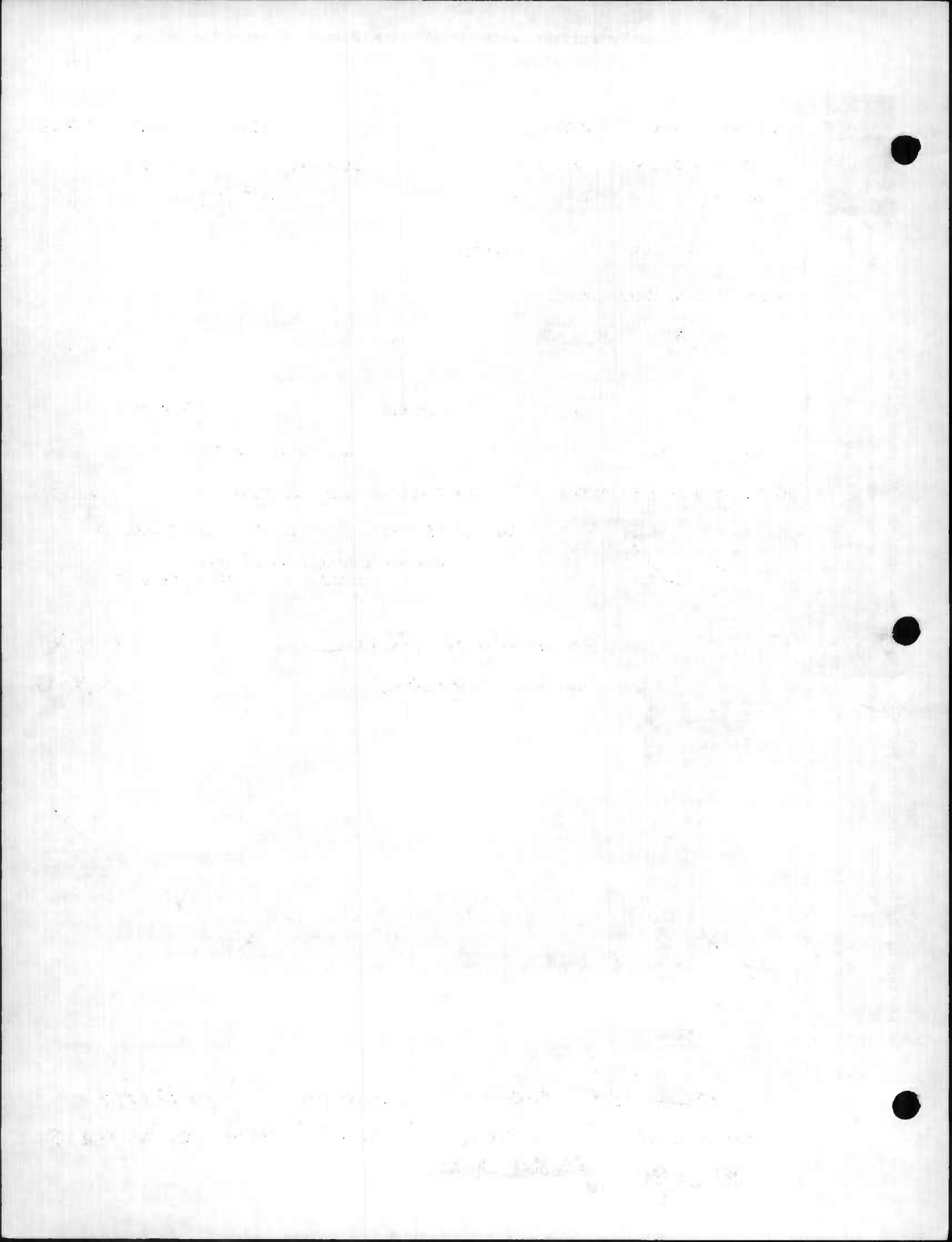
Physician
/Medical
Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38915

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Raymond Leroy Fridinger

2. Date of Death

Dec. 23 1997

3. Time of Death

7:00 am.

4a. Facility Name (If not institution, give street and number)

3223 Maple Ave.

4b. City, Town, or Location of Death

Manchester

4c. County of Death

Carroll

Funeral
Director

5. Social Security Number

219-14-8209

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

78

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Feb. 26, 1919

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Carroll

10c. City, Town or Location

Manchester

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

3223 Maple Ave.

10f. Zip Code

21102

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☒ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
☐ Yes ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

Collage (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Plumber

16b. Kind of Business/Industry

Plumbing & Heating

17. Father's Name (First, Middle, Last)

Bert Fridinger

18. Mother's Name (First, Middle, Maiden Summa)

Mamie Therit

19a. Informant's Name/Relationship (Type, Print)

Lola L. Fridinger - wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3223 Maple Ave. Manchester, Md. 21102

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

John Luther Miller Cem. Dec. 26, 1997

Date

Westminster, Md.

21. Signature of Funeral Service Licensee

J. H. Eshelb

22. Name and Address of Facility

Eckhardt Funeral Chapel
3296 Charmil Dr. Manchester, Md. 21102

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Cor D

s. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

28. Place of Death (Check only one)

Hospital:

☐ Inpatient

☐ ER/Outpatient

☐ DOA

Other:

☐ Nursing Home

☒ Residence

☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending Investigation
☐ Accident ☐ Could not be determined
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

J. H. Eshelb

29c. License number

233165

29d. Date signed (Month, Day, Year)

12/23/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Steven Shaffer 2111 Hanover Pike Manchester 21102

31. Date filed (Month, Day, Year)

DEC 24 1997

32. Registrar's Signature

J. H. Eshelb

State Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Items: 23 part I, 27, 28a-f per ME0 G-755 1/2/98 ^{reb} Certificate of Death

Reg. No.

97 38916

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician
/Medical
Examiner

Funeral
Director

Physician
/Medical
Examiner

| | | | | | | | |
|---|--|--|---|--|---|---|--|
| 1. Decedent's Name (First, Middle, Last) JEFFERY GRAHAM | | 2. Date of Death Month December Day 18 Year 1997 | | 3. Time of Death 0500a | | | |
| 4a. Facility Name (If not institution, give street and number) FRANKLIN SQUARE HOSPITAL | | | 4b. City, Town, or Location of Death ESSEX | | 4c. County of Death BALTIMORE | | |
| 5. Social Security Number 214-78-9555 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 38 Yrs. | | 8. Date of Birth (Month, Day, Year) Sept. 25 1959 | |
| 9. Birthplace (State or Foreign Country) MD | | 10a. State MD | | 10b. County NA | | 10c. City, Town or Location BALTIMORE | |
| 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number 2826 HARLEM AVE. | | 10f. Zip Code 21216 | | 10g. Citizen of What Country? USA | |
| 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No 12-78 If Yes, Give Year or Dates: 2-81 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: BLACK | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) NA | | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) TRUCK DRIVER | | 16b. Kind of Business/Industry Consignment Shop | | | |
| 17. Father's Name (First, Middle, Last) JOE SOLOMON | | | 18. Mother's Name (First, Middle, Maiden Surname) SHIRLEY GRAHAM | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Shirley Solomon- Mother | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2826 Harlem Ave. Balto., MD 21216 | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Garrison Forest Vet. | | Date 122497 | | 20c. Location - City or Town, State Owings Mills, Md | |
| 21. Signature of Funeral Service Licensee <i>Gabrielle Cook</i> | | 22. Name and Address of Facility Wm C. March Funeral Home-West. Inc 4300 Wabash Ave. Balto., MD 21215 | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. NARCOTIC AND ALCOHOL INTOXICATION Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | | | | | Approximate Interval Between Onset and Death | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | |
| | | | | | | 24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) found 12/18/97 | | 28b. Time of Injury found at 4:57 | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | | 28d. Describe how injury occurred Unknown | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) found at home | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) 308 Hamilton Ave. #2a Baltimore Co. Md. | |
| 29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier <i>Stephen A. Radentz, MD</i> | | 29c. License number O.C.M.E. | | 29d. Date signed (Month, Day, Year) December 18, 1997 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stephen S. Radentz, MD 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 24 1997 | | 32. Registrar's Signature <i>John Davidson-Randall</i> | | | | | |

WRC
97-7389-005
NORBERT R.
GEBHARDT

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Items: 23a part I, II, 27, 28a-f per ME0 G-755 1/21/98 dh

Reg. No. 97 38917

| | | | | | | | | | | |
|--|--|--|--|--|--|---|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Norbert Raymond Gebhardt | | | | 2. Date of Death Month Day Year DEC. 22, 1997 | | 3. Time of Death 4:43 PM. | | | |
| | 4e. Facility Name (If not institution, give street and number) FRANKLIN SQUARE HOSPITAL | | | | 4b. City, Town, or Location of Death BALTIMORE | | 4c. County of Death Baltimore | | | |
| Funeral Director | 5. Social Security Number 220-40-7595 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 54 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) Oct. 7, 1943 | 9. Birthplace (State or Foreign Country) Maryland | | |
| | Usual Residence of Decedent | | | | | | | | | |
| To Be Completed by Funeral Director | 10e. State Maryland | | 10b. County Baltimore | | 10c. City, Town or Location Middle River | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | 10a. Street and Number 1121 Cold Spring Road | | | | 10f. Zip Code 21220 | | 10g. Citizen of What Country? U.S.A. | | | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 6 | | 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Engineer | | | 16b. Kind of Business/Industry Gas & Electric | | | | |
| | 17. Father's Name (First, Middle, Last) Norbert Richard Gebhardt | | | | 18. Mother's Name (First, Middle, Maiden Surname) Justine Christensen | | | | | |
| Physician /Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) Kimberly Ann Gebhardt (Daughter) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6006 Westwood Avenue Baltimore, Md. 21206 | | | | | |
| | 20e. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Greenmount Crematory | | Date 12/29/1997 | | 20c. Location - City or Town, State Baltimore, Md. | | | |
| | 21. Signature of Funeral Service Licensed  | | | | 22. Name and Address of Facility Brudzinski Funeral Home P.A. 1407 Old Eastern Avenue Essex, Md. 21221 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. HEAD AND NECK INJURIES Due to (or as a consequence of): f. Due to (or as a consequence of): g. Due to (or as a consequence of): h. Due to (or as a consequence of): Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | Approximate Interval Between Onset and Death | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| | 27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide | | 28e. Date of Injury (Month, Day, Year) 12/22/97 | | 28b. Time of Injury 3:54 P M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred Driver in auto/fixed object impact | |
| | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) 2800 Eastern Blvd., Baltimore Co., Md. | | | | | | | |
| | 29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| | 29b. Signature and title of certifier  J. Aaron Locke, MD | | | | 29c. License number O.C.M.E. | | 29d. Date signed (Month, Day, Year) DEC. 23, 1997 | | | |
| State Registrar | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) J. Aaron Locke, MD 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | | |
| | 31. Date filed (Month, Day, Year) DEC 24 1997  | | | | | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 38918
Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Jean M. Gaither

2. Date of Death

December 20, 1997 11:00 A.M.

3. Time of Death

Funeral
Director

4a. Facility Name (If not institution, give street and number)

SAINT AGNES NURSING HOME

4b. City, Town, or Location of Death

ELLCOTT CITY

4c. County of Death

HOWARD

5. Social Security Number

217-12-5389

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

74 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

MAY 7, 1923

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

HOWARD

10c. City, Town or Location

ELLCOTT CITY

10d. Inside City Limits

1 ☐ Yes ☒ No

10e. Street and Number

9233 WEST STAYMAN DRIVE

10f. Zip Code

21042

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: WHITE

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

SECRETARY

16b. Kind of Business/Industry

JOHN'S HOPKINS
APPLIED PHYSICS LAB

17. Father's Name (First, Middle, Last)

ROBERT C. OWENS

18. Mother's Name (First, Middle, Maiden Surname)

ANNIE LAURIE PATTERSON

19a. Informant's Name/Relationship (Type, Print)

HERBERT GAITHER, HUSBAND

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9233 WEST STAYMAN DRIVE, ELLCOTT CITY, MD 21042

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

POPLAR SPRINGS CEMETERY

Date

12/23/97

20c. Location - City or Town, State

LISBON, MARYLAND

21. Signature of Funeral Service Licensee

RCW

22. Name and Address of Facility

WITZKE FUNERAL HOMES, INC.
1630 EDMONDSON AVENUE, CATONSVILLE, MD 2122823a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)e. Respiratory Failure
Due to (or as a consequence of):b. Lung Cancer
Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

1 year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Aspergillosis pneumonia

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician2 ☐ Medical ExaminerTo the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

MD

29c. License number

035309

29d. Date signed (Month, Day, Year)

December 22, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

S. Sattin M.D. 2850 N. Ridge Rd, Ellicott City, md 21043

31. Date filed (Month, Day, Year)

DEC 24 1997

32. Registrar's Signature

Julia Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

1000

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38919

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ROLAND HAYWOOD

2. Date of Death

December 22 1997

3. Time of Death

3:15 Am

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Liberty Medical

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

5. Social Security Number

215-28-3139

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

66 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Nov. 27, 1931

9. Birthplace (State or Foreign Country)

Md

Usual Residence of Decedent

10a. State
Md

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3332 Burleigh Ave

10f. Zip Code

21215

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: 2-16-53

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12th grade

College (1-4 or 5+)

Hydars

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Teacher

16b. Kind of Business/Industry

Baltimore City Public School

17. Father's Name (First, Middle, Last)

Roland Haywood Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Edna Blackwell

19a. Informant's Name/Relationship (Type, Print)

Constance Haywood / wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3332 Burleigh Ave. Baltimore, Md 21215

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Garrison Forest

Date

12-26-97 Owings Mills, Md

21. Signature of Funeral Service Licensee

Gabrielle Cook

22. Name and Address of Facility

William C March F/H - West
4300 Wabash Ave Baltimore, Md 21215

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Gastro Intestinal BLEEDING

Due to (or as a consequence of):

b. ALCOHOL ABUSE

Due to (or as a consequence of):

c. SEVERE ANEMIA

Due to (or as a consequence of):

d. Aspiration pneumonia

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

cardiopulmonary arrest

Anoxic encephalopathy

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Terance L. Lamb M.D.

29c. License number

D37203

29d. Date signed (Month, Day, Year)

December 22, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Terance L. Lamb M.D. Liberty Medical Center, Baltimore Md 21215

31. Date filed (Month, Day, Year)

DEC 24 1997

32. Registrar's Signature

John Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38920

| | | | | | | | | |
|--|--|---|--|--|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Margaret M. Hart | | | | 2. Date of Death Month Day Year December 21, 1997 | | 3. Time of Death 8:30 PM | |
| | 4a. Facility Name (If not institution, give street and number) 7615 Sparrows Point Road | | | | 4b. City, Town, or Location of Death Edgemere | | 4c. County of Death Baltimore | |
| Funeral Director | 5. Social Security Number 220-05-0906 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 76 Yrs. | 8. Date of Birth (Month, Day, Year) Aug. 1, 1921 | | 9. Birthplace (State or Foreign Country) Maryland | |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State Maryland | | 10b. County Baltimore | | 10c. City, Town or Location Edgemere | | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| 10e. Street and Number 7615 Sparrows Point Road | | | | 10f. Zip Code 21219 | | 10g. Citizen of What Country? United States | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 Years College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Baker | | | 16b. Kind of Business/Industry Board of Education | |
| 17. Father's Name (First, Middle, Last) Louis Burkman | | | | 18. Mother's Name (First, Middle, Maiden Surname) Edith Nuttle | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Mr. John G. Hart / Husband | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7615 Sparrows Pt. Road Edgemere, Maryland 21219 | | | | |
| 20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input checked="" type="checkbox"/> Other (Specify) Entombment | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Gardens of Faith Cem. | | Date 12/24/97 | | 20c. Location - City or Town, State Rossville, Maryland | | |
| 21. Signature of Funeral Service Licensee  | | | | 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death |
| a. renal failure Due to (or as a consequence of): b. heart failure (CHF) Due to (or as a consequence of): c. stroke Due to (or as a consequence of): d. | | | | | | | | 1-2 wks 1-2 wks 4 mos. |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. arrhythmia - afib | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how Injury occurred |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier  | | 29c. License number D46289 | | 29d. Date signed (Month, Day, Year) 12/22/97 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Belinda Y. Chen, MD 2112 Dundalk Avenue Baltimore, MD 21222 | | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 24 1997 | | 32. Registrar's Signature  | | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 38921

Certificate of Death

Reg. No.

| | | | | | | | | | | |
|--|---|---------------------------------|---|---|--|--------------------------------|---|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Thelma M. Hecht | | | | 2. Date of Death Month December Day 21 Year 1997 | | | | 3. Time of Death 4:27 PM | |
| | 4a. Facility Name (If not institution, give street and number) Johns Hopkins Bayview Medical Ctr. | | | | 4b. City, Town, or Location of Death Baltimore City | | | | 4c. County of Death N/A | |
| Funeral Director | 5. Social Security Number 220-14-7138 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 74 Yrs. | | 8. Date of Birth (Month, Day, Year) June 3, 1923 | | 9. Birthplace (State or Foreign Country) Maryland | |
| | Usual Residence of Decedent | | | | | | | | | |
| 10a. State Maryland | | 10b. County Baltimore | | 10c. City, Town or Location Edgemere | | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 10e. Street and Number 3111 Greenhill Road | | | | 10f. Zip Code 21219 | | | | 10g. Citizen of What Country? United States | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 Years | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Housewife | | | | 16b. Kind of Business/Industry Own Home | | |
| 17. Father's Name (First, Middle, Last) David William Lee | | | | | 18. Mother's Name (First, Middle, Maiden Surname) Ruth Louise Nizer | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) David Hecht / Son | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3 J Loring Court Edgemere, Maryland 21219 | | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Oak Lawn Cemetery | | | 20c. Date 12/24/1997 | | 20d. Location - City or Town, State Baltimore, Maryland | | |
| 21. Signature of Funeral Service Licensee  | | | | | 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Severe Dehydration Due to (or as a consequence of): b. colitis & Diarrhea, probably viral 2-3 days Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Severe Dehydration colitis & Diarrhea, probably viral 2-3 days Hypertension, Essential | | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | | | |
| 23c. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | |
| 23d. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | | |
| 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | | |
| 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> Outpatient Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | |
| 29b. Signature and title of certifier  | | | | | 29c. License number DO9352 | | 29d. Date signed (Month, Day, Year) 12/24/97 | | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) R.S. MAGNO, MD. 7811 Wise Ave. BALTO. MD 21222 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 24 1997 | | | | | 32. Registrar's Signature  | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

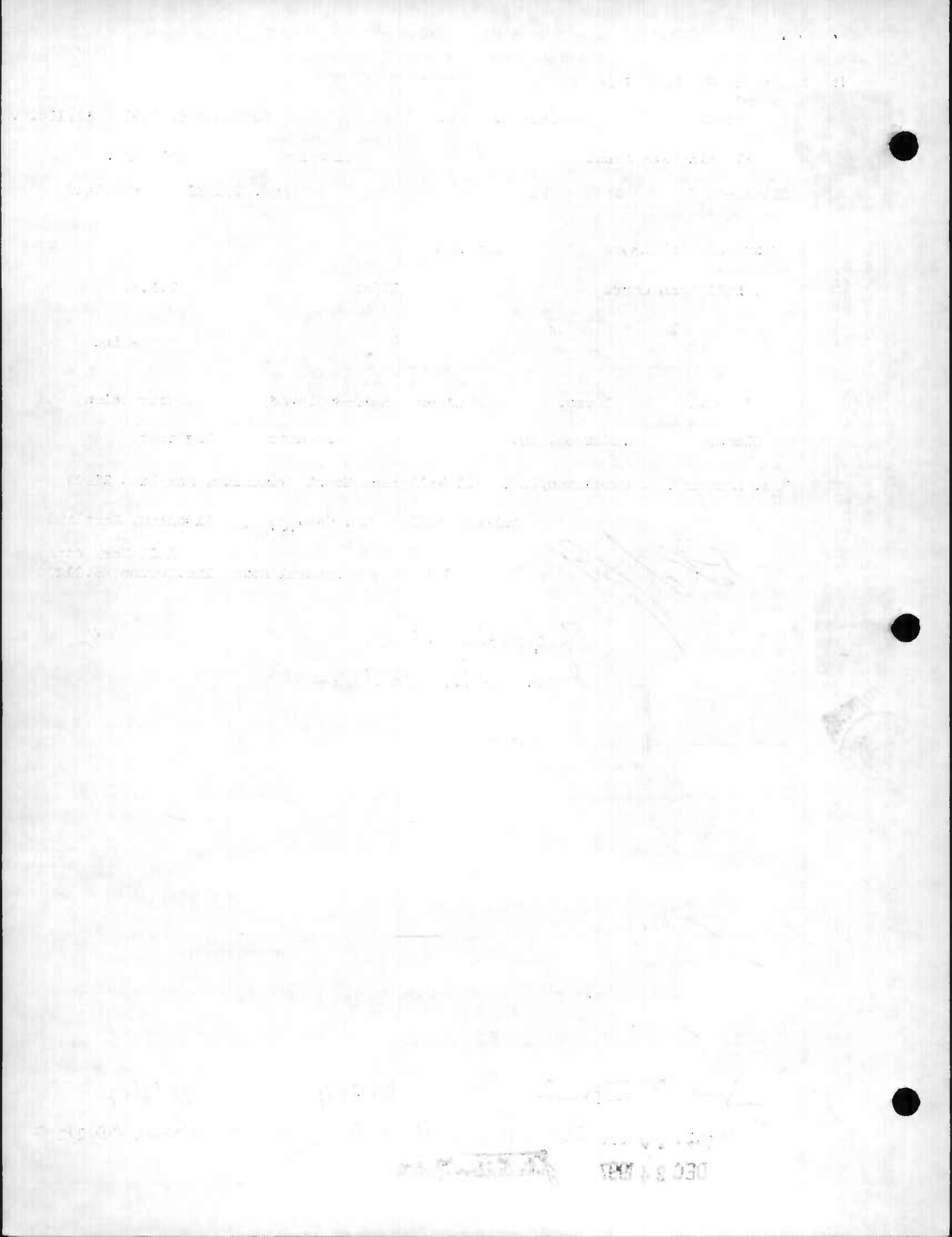
To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Handwritten signature

1921 6 3 110



DEC 8 1961

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

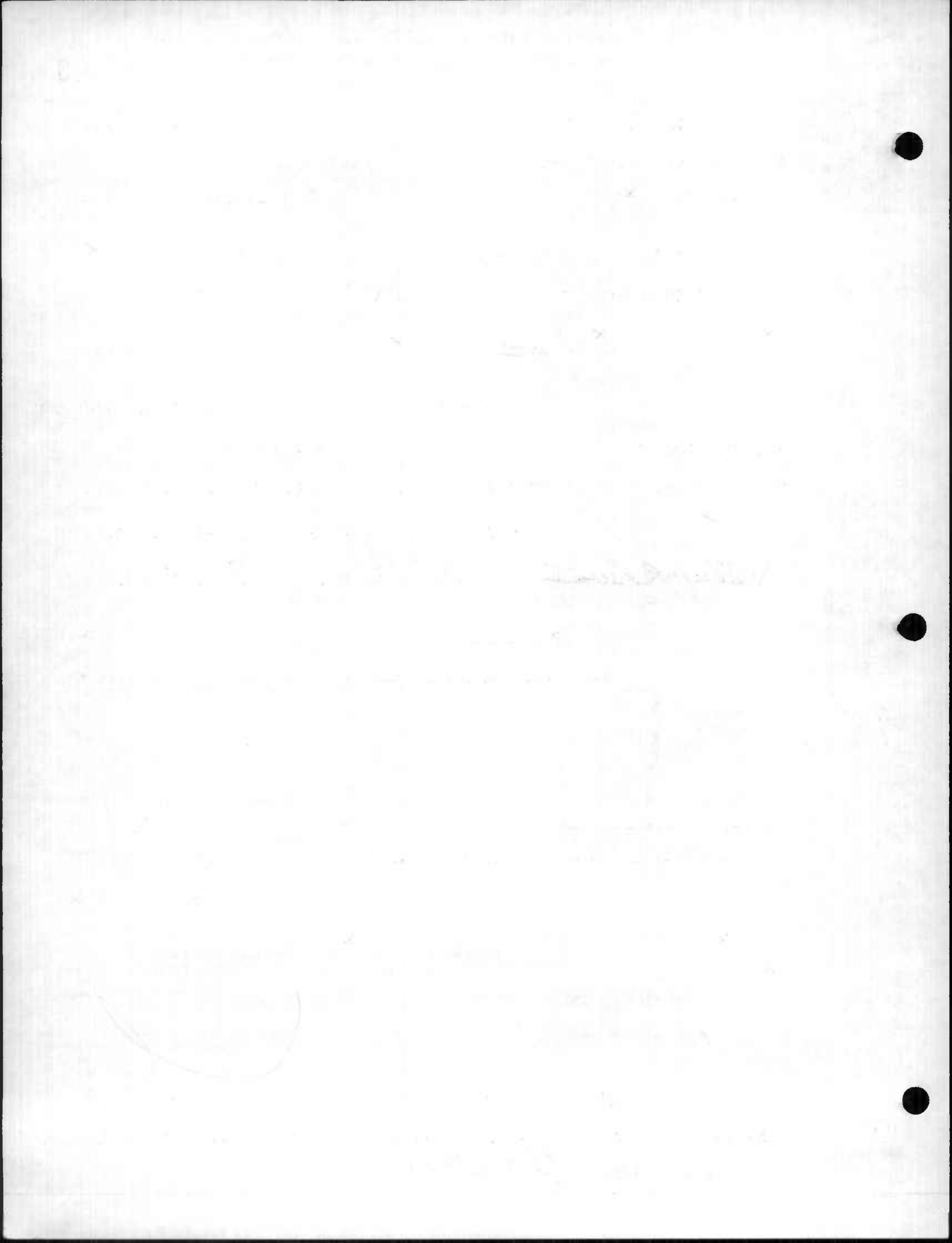
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38923

| | | | | | |
|--|---|---|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) FRANCIS D. HANDY | | 2. Date of Death Month 12 - Day 19 Year 1997 | | 3. Time of Death 12:15 pm |
| | 4a. Facility Name (If not institution, give street and number) KESWICK MULTI-CARE CENTER | | 4b. City, Town, or Location of Death BALTIMORE | | 4c. County of Death |
| Funeral Director | 5. Social Security Number 219-28-4325 | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 85 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. |
| | 8. Date of Birth (Month, Day, Year) 12-18-1912 | | 9. Birthplace (State or Foreign Country) MARYLAND | | |
| To Be Completed by Funeral Director | Usual Residence of Decedent | | 10a. State MD. | | 10b. County N/A |
| | 10c. City, Town or Location BALTIMORE | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | 10e. Street and Number 700 WEST 40TH STREET | | 10f. Zip Code 21211 | | 10g. Citizen of What Country? USA |
| | 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WWII | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
| | 14. Race - American Indian, Black, White, etc. Specify: WHITE | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 5+ College (1-4 or 5+) 5+ | | |
| To Be Completed by Physician/Medical Examiner | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) LAWYER | | 16b. Kind of Business/Industry MARYLAND CASUALTY | | |
| | 17. Father's Name (First, Middle, Last) KINGMAN HANDY | | 18. Mother's Name (First, Middle, Maiden Surname) SADIE DAVIS | | |
| | 19a. Informant's Name/Relationship (Type, Print) FREDERICK S. KOONTZ (ATTORNEY) | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7 ST. PAULS ST. BALTO., MD. 21202. | | |
| | 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) GREEN MOUNT CREMATORY | | 20c. Location - City or Town, State 12/22 BALTO., MD. |
| | 21. Signature of Funeral Service Licensee  | | 22. Name and Address of Facility HENRY W. JENKINS & SONS CO. 4905 YORK RD. BALTO., MD. 21212. | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Pneumonia Due to (or as a consequence of): Giant Cell Arteritis & Complications of Corticosteroid Therapy Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): | | | | | Approximate Interval Between Onset and Death 6 days |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Ischemic Cardiomyopathy Supraventricular Tachycardia & Complete Atrial Fibrillation | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 28d. Describe how Injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | |
| 29b. Signature and title of certifier  | | 29c. License number 12399 | | 29d. Date signed (Month, Day, Year) December 20, 1997 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHARLES O'DONOVAN M.D. G.B.M.C. EAST PAVILLION SUITE 509 TOWSON, MD. | | | | | |
| 31. Date filed (Month, Day, Year) DEC 24 1997 | | 32. Registrar's Signature  | | | |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

NANCY
HARDESTY

Physician
/Medical
Examiner

Funeral
Director

| | | | | | | | |
|--|--|---|--|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last) Nancy Christine Hardesty | | | | 2. Date of Death Month Day Year DECEMBER 22, 1997 | | 3. Time of Death 8:40A.M. | |
| 4a. Facility Name (If not institution, give street and number) ANNE ARUNDEL GENERAL HOSPITAL | | | | 4b. City, Town, or Location of Death ANNAPOLIS | | 4c. County of Death ANNE ARUNDEL | |
| 5. Social Security Number 088-38-7534 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 51 Yrs. | | 8. Date of Birth (Month, Day, Year) June 29, 1946 | |
| 9. Birthplace (State or Foreign Country) New York | | 10a. State MD | | 10b. County Anne Arundel | | 10c. City, Town or Location 3571 Loch Haven Road, Edgewater | |
| 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 10e. Street and Number 3571 Loch Haven Road | | 10f. Zip Code 21037 | | 10g. Citizen of What Country? USA | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 1 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) School Crossing Guard | | 16b. Kind of Business/Industry Law Enforcement | | | |
| 17. Father's Name (First, Middle, Last) Daniel Howard O'Brien | | | | 18. Mother's Name (First, Middle, Maiden Surname) Lillian Mae Sager | | | |
| 19a. Informant's Name/Relationship (Type, Print) Robert Bernard Hardesty- Husband | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3571 Loch Haven Road, Edgewater, MD 21037 | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Lakemont Cemetery | | Date 12/29 | | 20c. Location - City or Town, State Davidsonville, MD | |
| 21. Signature of Funeral Service Licensee Thomas A Hardesty | | | | 22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Ave. Annapolis, MD 21401 | | | |
| 23a. Pert I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Head Injuries Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): | | | | | | | Approximate Interval Between Onset and Death |
| Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | |
| | | | | | | 24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) 12/24/97 | | 28b. Time of Injury 0757 M | | 28c. Injury at Work? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | | 28d. Describe how injury occurred Crossing guard struck by auto | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) STREET | | | |
| | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) Rte. 214 and Mayford | | | | | |
| 29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. Signature and title of certifier John Locke MD | | | | 29c. License number O.C.M.E. | | 29d. Date signed (Month, Day, Year) DECEMBER 23, 1997 | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) J. ARON LOCKE, MD 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 24 1997 | | 32. Registrar's Signature Julia Davidson-Randall | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician
/Medical
Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. "natural" or items 23a or 28a-f show important: if item 27 is marked other than "natural", the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completed filed in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Items: 10a,b,c,e,f per Informant G-755 1/7/98 re

Certificate of Death

Reg. No.

97 38925

| | | | | | | | | | | | | | | | | | | | | | | |
|---|--|----------------------------------|---|--|---|--|---|--|---|--|---|---------------------|----------------------------------|----------------|-----------------------|----------------------------------|----------------|---|----------------------------------|----------------|----|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) LOUISE H. JAMISON | | | | 2. Date of Death Month 12 - Day 23 - Year 1997 | | | | 3. Time of Death 10:55pm | | | | | | | | | | | | | |
| | 4a. Facility Name (If not institution, give street and number) BLAKEHURST | | | | 4b. City, Town, or Location of Death TOWSON | | | | 4c. County of Death BALTIMORE | | | | | | | | | | | | | |
| Funeral Director | 5. Social Security Number 212-18-2040 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 83 Yrs. | | If Under 1 Year Months Days | | If Under 24 Hrs. Hours Min. | | | | | | | | | | | | | |
| | 8. Date of Birth (Month, Day, Year) 06-29-1914 | | 9. Birthplace (State or Foreign Country) MARYLAND | | 10a. State FLORIDA | | 10b. County BALTIMORE | | 10c. City, Town or Location NAPLES | | | | | | | | | | | | | |
| To Be Completed by Funeral Director | Usual Residence of Decedent | | | | | | | | | | | | | | | | | | | | | |
| | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 10e. Street and Number 1851 GULF SHORE BLVD., NORTH 1055 WEST JOPPA RD. | | 10f. Zip Code 21204 | | 10g. Citizen of What Country? USA | | | | | | | | | | | | | | | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | | | | | | | | | | | | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 1 YR. | | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOUSEWIFE | | 17. Kind of Business/Industry HOMEMAKER | | | | | | | | | | | | | | | | | |
| | 17. Father's Name (First, Middle, Last) JAMES MORRISON HARRIS | | | | 18. Mother's Name (First, Middle, Maiden Surname) LOUISE HAXALL | | | | | | | | | | | | | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print) LOUISA WYSKIEL (DAUGHTER) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 206 NORTHFIELD PLACE BALTO., MD. 21210/ | | | | | | | | | | | | | | | | | |
| | 20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) GREEN MOUNT CREMATORY | | 20c. Date 12/27/97 | | 20d. Location - City or Town, State BALTO., MD. | | | | | | | | | | | | | | | |
| | 21. Signature of Funeral Service Licensee <i>William R. Paust III</i> | | | | 22. Name and Address of Facility HENRY W. JENKINS & SONS CO. 4905 YORK RD. BALTO., MD. 21212. | | | | | | | | | | | | | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | | | | | | | | | | |
| | <table border="0"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last </td> <td>a. PNEUMONIA</td> <td>Due to (or as a consequence of):</td> <td>3 WEEKS</td> </tr> <tr> <td>b. NEUTROPENIA</td> <td>Due to (or as a consequence of):</td> <td>3 WEEKS</td> </tr> <tr> <td>c. CHEMOTHERAPY FOR CHRONIC LYMPHOCYTIC LEUKEMIA</td> <td>Due to (or as a consequence of):</td> <td>1 MONTH</td> </tr> <tr> <td>d.</td> <td></td> <td></td> </tr> </table> | | | | | | | | | | Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. PNEUMONIA | Due to (or as a consequence of): | 3 WEEKS | b. NEUTROPENIA | Due to (or as a consequence of): | 3 WEEKS | c. CHEMOTHERAPY FOR CHRONIC LYMPHOCYTIC LEUKEMIA | Due to (or as a consequence of): | 1 MONTH | d. | |
| Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. PNEUMONIA | Due to (or as a consequence of): | 3 WEEKS | | | | | | | | | | | | | | | | | | | |
| | b. NEUTROPENIA | Due to (or as a consequence of): | 3 WEEKS | | | | | | | | | | | | | | | | | | | |
| | c. CHEMOTHERAPY FOR CHRONIC LYMPHOCYTIC LEUKEMIA | Due to (or as a consequence of): | 1 MONTH | | | | | | | | | | | | | | | | | | | |
| | d. | | | | | | | | | | | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. RECENT PULMONARY TUBERCULOSIS STERIOD-DEPENDENT ASTHMA | | | | | | | | | | | | | | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | | | | | | | | | | | | | | | | | | | | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | | | |
| 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) | | | | | | | | | | | | | | | | | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | | | | | | | | | | | | | | | | | | | | | |
| 28a. Date of Injury (Month, Day, Year) | | | | | | | | | | | | | | | | | | | | | | |
| 28b. Time of Injury M | | | | | | | | | | | | | | | | | | | | | | |
| 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | | | |
| 28d. Describe how injury occurred | | | | | | | | | | | | | | | | | | | | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | | | | | | | | | | | | | | | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | | | | | | | | | | | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | | | | | | | | | | | | | |
| 29b. Signature and title of certifier <i>Lois E. Nielsen, MD</i> | | | | | | | | | | | | | | | | | | | | | | |
| 29c. License number D38327 | | | | | | | | | | | | | | | | | | | | | | |
| 29d. Date signed (Month, Day, Year) 12/24/97 | | | | | | | | | | | | | | | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LOIS NIELSEN M.D. 120 SISTER PIERRE DRIVE TOWSON, MD, 21204. | | | | | | | | | | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 24 1997 | | | | | | | | | | | | | | | | | | | | | | |
| 32. Registrar's Signature <i>Johanna Davidson-Randall</i> | | | | | | | | | | | | | | | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

38926

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last) Evelyn A. Kaloc
2. Date of Death Month Day Year Dec. 19, 1997
3. Time of Death 6:45 P.M.

Funeral
Director

4a. Facility Name (If not institution, give street and number) 125 Wallace Ave
4b. City, Town, or Location of Death Baltimore
4c. County of Death N/A

5. Social Security Number 214-22-0305
6. Sex 1 ☐ M 2 ☒ F
7. Age (In yrs. last birthday) 69 Yrs.
8. Date of Birth (Month, Day, Year) Sept. 22, 1928
9. Birthplace (State or Foreign Country) Maryland

Usual Residence of Decedent
10a. State Maryland
10b. County N/A
10c. City, Town or Location Baltimore
10d. Inside City Limits 1 ☒ Yes 2 ☐ No

10e. Street and Number 125 Wallace Ave
10f. Zip Code 21225
10g. Citizen of What Country? U.S.A.

11. Marital Status 1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12th
College (1-4 or 5+) N/A
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Secretary
16b. Kind of Business/Industry U.S. Army

17. Father's Name (First, Middle, Last) William Rich
18. Mother's Name (First, Middle, Maiden Surname) Frances Radecke

19a. Informant's Name/Relationship (Type, Print) Emil F. Kaloc (Husband)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 125 Wallace Ave Baltimore, Maryland 21225

20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place) Cedar Hill Cemetery Dec. 24, 1997
20c. Location - City or Town, State Baltimore, Maryland

21. Signature of Funeral Service Licensee
22. Name and Address of Facility McCully-Polyniak Funeral Home
237 E. Patapsco Ave Baltimore, Maryland 21225

23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death) a. Breast cancer
Due to (or as a consequence of):
Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

23b. Did tobacco use contribute to the cause of death?
1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one)
Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☒ No
28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier Dr. Markay M.D.
29c. License number D39505
29d. Date signed (Month, Day, Year) Dec. 22, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) YUDHISH MARKAN 1406-B CRAIN HWY #202, GLEN BURNIE, MD. 21061

31. Date filed (Month, Day, Year) DEC 24 1997
32. Registrar's Signature Julia Davidson-Randall

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

10

State
Registrar

1999.05.20 2000.05.20

1999.05.20 2000.05.20

1999.05.20 2000.05.20

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38927

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

LOUIS M. KAWECKI, SR.

2. Date of Death
Month Day Year

December 23, 1997

3. Time of Death

5:29am

4a. Facility Name (If not institution, give street and number)

North Arundel Hospital

4b. City, Town, or Location of Death

glen Burnie

4c. County of Death

Anne Arundel

Funeral
Director

5. Social Security Number

212-14-8400

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

75

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Jan. 18, 1922

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Pasadena

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8123 Ventnor Road

10f. Zip Code

21122

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married

3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Electrician

16b. Kind of Business/Industry

British

Petroleum

17. Father's Name (First, Middle, Last)

Louis Jacob Kaweck

18. Mother's Name (First, Middle, Maiden Surname)

Myrtle Henning

19a. Informant's Name/Relationship (Type, Print)

Lena Kaweck / wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8123 Ventnor Road Pasadena, Maryland 21122

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

St. Stanislaus Cemetery

Date

Dec. 27,

1997

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Alan C. Davis

22. Name and Address of Facility

McCully-Polyniak Funeral Home

3204 Mountain Road Pasadena, MD. 21122

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Acute Myocardial Infarction

Due to (or as a consequence of):

Coronary Artery Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 Day

5 Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Pneumonia Myocardial Infarction

Non-traumatic Spontaneous Aortic Dissection

Cardiac Arrhythmia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient

2 ☒ ER/Outpatient

3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home

5 ☐ Residence

6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural

2 ☐ Accident

3 ☐ Suicide

4 ☐ Homicide

5 ☐ Pending investigation

6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician

2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Whymore M. Attending Doctor

29c. License number

D21684

29d. Date signed (Month, Day, Year)

12-23-97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

C.V. CYRIAC M.D. 8109 RITCHIE AVE, PASADENA, MD 21122

31. Date filed (Month, Day, Year)

32. Registrar's Signature

[Signature]

State Registrar

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

KAWECKI LOUIS

PC

6/1

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 38928

Certificate of Death

Reg. No.

| | | | | | |
|--|--|--|---|--------------------------------|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) EDNA, Lewis | | 2. Date of Death Month December Day 17 Year 1997 | | 3. Time of Death 9:00 AM |
| | 4a. Facility Name (If not institution, give street and number) Liberty Medical Center | | 4b. City, Town, or Location of Death Baltimore | | 4c. County of Death NA |
| Funeral Director | 5. Social Security Number 246-12-7244 | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 74 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. |
| | 8. Date of Birth (Month, Day, Year) 8-14-1923 | | 9. Birthplace (State or Foreign Country) N.C. | | |
| To Be Completed by Funeral Director | Usual Residence of Decedent | | 10a. State MD | | 10b. County NA |
| | 10c. City, Town or Location Baltimore | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | 10e. Street and Number 3803 Barrington | | 10f. Zip Code 21215 | | 10g. Citizen of What Country? U.S.A |
| | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
| | 14. Race - American Indian, Black, White, etc. Specify: Black | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th grade College (1-4 or 5+) 4 yrs | | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Teacher |
| | 17. Father's Name (First, Middle, Last) Haywood H. Wood | | 18. Mother's Name (First, Middle, Maiden Surname) I I A Parsons | | |
| | 19a. Informant's Name/Relationship (Type, Print) Elinor Gerard - Niece | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5 Shadow Lane Hopewell Jct, N.Y. 12533 | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Garrison Forest VET | | 20c. Location - City or Town, State 12-2397 Owings Mills, MD |
| | 21. Signature of Funeral Service Licensee Gala March | | 22. Name and Address of Facility March F.H. West 4300 Wabash Avenue Baltimore | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sepsis Due to (or as a consequence of): Dehydration Due to (or as a consequence of): Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Severe Anemia Pseudo Aneurysm of Ascending Aorta Aneurysm of Descending Aorta | | | | |
| 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | | | | |
| 28a. Date of Injury (Month, Day, Year) | | | | | |
| 28b. Time of Injury M | | | | | |
| 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 28d. Describe how injury occurred | | | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | |
| 29b. Signature and title of certifier Kwame N. Kwame | | | | | |
| 29c. License number D17031 | | | | | |
| 29d. Date signed (Month, Day, Year) December 17, 1997 | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Liberty Medical Center, Liberty Height Ave. Baltimore, MD 21215 | | | | | |
| 31. Date filed (Month, Day, Year) DEC 24 1997 | | | | | |
| 32. Registrar's Signature Julia Davidson-Randall | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

DANTE LAFAVORS

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38929

ASP

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

DANTE DARNELL LAFAVORS

2. Date of Death
Month Day Year
DECEMBER 20 19973. Time of Death
2350 P

4a. Facility Name (If not institution, give street and number)

300 BLK N. GREENE ST.

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

NA

Funeral
Director

5. Social Security Number

217-92-5293

6. Sex

1 ☐ M 2 ☐ F
XX

7. Age (In yrs. last birthday)

18 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Dec. 28, 1978

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

BALTIMORE

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

5 SENTA COURT

10f. Zip Code

21207

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12thCollege (1-4or 5+)
1+16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

16b. Kind of Business/Industry

17. Father's Name (First, Middle, Last)

WILLIAM LAFAVORS

18. Mother's Name (First, Middle, Maiden Surname)

BARBARA CLARK

19a. Informant's Name/Relationship (Type, Print)

Wm & Barbara LaFavors-Parents

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5 Senta Court Baltimore, Md. 21207

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Loudon Park Cemetery 12-27-97 Baltimore, Md

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Wm C. March Funeral Home-West, Inc.
4300 Wabash Ave. Balto., MD 21215

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

Due to (or as a consequence of):

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) SCENE

27. Manner of Death

1 ☐ Natural 2 ☒ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)
12-20-97

28b. Time of Injury

2344 M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

Driver struck by 20' object

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Street

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Mulberry & Greene Sts

29a. Certifier
(Check only one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

O.C.M.E

29d. Date signed (Month, Day, Year)

DECEMBER 21, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

A. M. Dixon

111 Penn Street, Baltimore, Maryland 21201

State
Registrar

31. Date filed (Month, Day, Year)

DEC 24 1997

32. Registrar's Signature

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

VOID

CERTIFICATE #

97-38930

SEE

CERTIFICATE #

97-41533

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 38931

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Ellsworth S. LaMar

2. Date of Death

Month Day Year
Dec. 18, 1997

3. Time of Death

10:00 A.M.

4a. Facility Name (If not institution, give street and number)

3812 8th Street

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

214-16-9853

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

78

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
April 2, 1919

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

3812 8th Street

10f. Zip Code

21225

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☒ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
☒ Yes ☐ No 1940-
If Yes, Give
Year or Dates: 194513. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4 or 5+)

N/A

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Firefighter

16b. Kind of Business/Industry

Baltimore City

17. Father's Name (First, Middle, Last)

George

LaMar

18. Mother's Name (First, Middle, Maiden Surname)

Helen

Deering

19a. Informant's Name/Relationship (Type, Print)

Norma C. LaMar (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3812 8th Street Baltimore, Maryland 21225

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Cedar Hill Cemetery

Date

12/22/97

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

McCully-Polyniak Funeral Home, Inc.
237 East Patapsco Ave. Baltimore, Md 2122523a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

e. Acute Myocardial Infarction

1 DAY

Due to (or as a consequence of):

b. Hypertensive Coronary Artery Disease

1969

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Last

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes 10/93

Prostate Cancer 8/95

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown24a. Was an autopsy
performed?☐ Yes ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?☐ Yes ☒ No25. Was case referred to medical
examiner?☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient☐ ER/Outpatient☐ DOA

Other:

☒ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Pending Investigation☐ Accident☐ Suicide☐ Homicide☐ Could not be determined28a. Date of Injury
(Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only one)☐ Certifying Physician☒ Medical ExaminerTo the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and Title of Certifier

29c. License number

D31144

29d. Date signed (Month, Day, Year)

12-18-97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

4710 Pennington Avenue, Baltimore, Maryland

31. Date filed (Month, Day, Year)

DEC 21 1997

32. Registrar's Signature

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38932

| | | | | | | | | | | |
|--|--|--|-----------------|---|---|--|---|---|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) GARY ALLEN PINDER | | | | 2. Date of Death Month Day Year DECEMBER 17, 1997 | | | | 3. Time of Death 10 pm | |
| | 4a. Facility Name (If not institution, give street and number) 7 DAMIAN COURT APT2D | | | | 4b. City, Town, or Location of Death ROSEDALE | | | | 4c. County of Death BALTIMORE | |
| Funeral Director | 5. Social Security Number 216420985 | | 6. Sex M 2 F | | 7. Age (In yrs. last birthday) 53 Yrs. | | 8. Date of Birth (Month, Day, Year) JAN 27, 1944 | | 9. Birthplace (State or Foreign Country) MARYLAND | |
| | Usual Residence of Decedent | | | | | | | | | |
| 10e. State MD | | 10b. County BALTIMORE | | 10c. City, Town or Location ROSEDALE | | | | 10d. Inside City Limits 1 Yes 2 No | | |
| 10e. Street and Number 7 DAMIAN COURT APT 2D | | | | 10f. Zip Code 21237 | | | | 10g. Citizen of What Country? USA | | |
| 11. Marital Status 1 X Never Married 2 Married 3 Widowed 4 Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 0 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) MAINTENANCE MECH. | | | | 16b. Kind of Business/Industry MAINTENANCE | | |
| 17. Father's Name (First, Middle, Last) EDWARD E. PINDER | | | | 18. Mother's Name (First, Middle, Maiden Surname) ANNIE PORTER | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) PATRICIA M. WHITESELL/FIANCÉE | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7 DAMIAN COURT APT 2D ROSEDALE, MD 21237 | | | | | | |
| 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) GARDENS OF FAITH | | 20c. Date 12/20 | | 20d. Location - City or Town, State BALTIMORE, MD | | | | |
| 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 1211 CHESACO AVE BALTO, MD 21237 | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. Carcinomatous Meningitis Due to (or as a consequence of): b. Metastatic Adenocarcinoma of Due to (or as a consequence of): c. @ heart Due to (or as a consequence of): d. | | | | | | | | Approximate Interval Between Onset and Death 6 wk 12 month | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 X Yes 2 No 3 Probably 4 Unknown | | |
| | | | | | | | | 24e. Was an autopsy performed? 1 Yes 2 No | | |
| | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No | | |
| 25. Was case referred to medical examiner? 1 Yes 2 No | | 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) | | | | | | | | |
| 27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 Yes 2 No | | 28d. Describe how injury occurred | | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one) 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier Davis M Hahn | | | | 29c. License number AH 7752579 | | 29d. Date signed (Month, Day, Year) 12/19/97 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Davis M Hahn 5801 Loch Raven Blvd Balto. MD 21239 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 24 1997 | | | | | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760

10/10/1918

Dear Sir,

I have the honor to acknowledge the receipt of your letter of the 10th inst. in relation to the above matter.

I am sorry that I cannot give you a more definite answer at this time, but I am sure that you will understand my position.

I am, Sir, very respectfully,
Yours truly,
J. H. [Signature]

Very truly,
J. H. [Signature]

10/10/1918

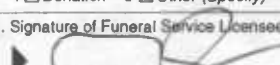
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38933

| | | | | | | | | | |
|--|---|--|--|--|--|---|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Sylvan James Placek | | | | 2. Date of Death Month Day Year December 22, 1997 | | 3. Time of Death 7:00 pm | | |
| | 4a. Facility Name (If not institution, give street and number) 1238 LANDOVER ROAD | | | | 4b. City, Town, or Location of Death ROSEDALE | | 4c. County of Death BALTIMORE | | |
| Funeral Director | 5. Social Security Number 213039380 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (in yrs. last birthday) 98 Yrs. | | 8. Date of Birth (Month, Day, Year) March 12, 1899 | | |
| | 9. Birthplace (State or Foreign Country) MINNESOTA | | 10a. State MD | | 10b. County BALTIMORE | | 10c. City, Town or Location ROSEDALE | | |
| To Be Completed by Funeral Director | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 10e. Street and Number 1238 LANDOVER ROAD | | | |
| | | 10f. Zip Code 21237 | | | | 10g. Citizen of What Country? USA | | | |
| | | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | | |
| | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | | | |
| | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4or 5+) 0 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) FOREMAN | | | |
| | | 16b. Kind of Business/Industry MEAT PACKING | | | | | | | |
| | | 17. Father's Name (First, Middle, Last) JOSEPH PLACEK | | | | 18. Mother's Name (First, Middle, Maiden Surname) BARBARA MIKESH | | | |
| | | 19a. Informant's Name/Relationship (Type, Print) EDWARD E. PLACEK / SON | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1238 LANDOVER ROAD ROSEDALE, MD 21237 | | | |
| | | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) BEL AIR MEMORIAL | | 20c. Location - City or Town, State 12/26 BEL AIR, MARYLAND | |
| | | 21. Signature of Funeral Service Licensee  | | | | 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 1211 CHESACO AVE BALTO, MD 21237 | | | |
| Physician /Medical Examiner | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <div style="margin-left: 100px;">a. Acute Leukemia Due to (or as a consequence of):</div> <div style="margin-left: 100px;">b. Due to (or as a consequence of):</div> <div style="margin-left: 100px;">c. Due to (or as a consequence of):</div> <div style="margin-left: 100px;">d. Due to (or as a consequence of):</div> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | Approximate Interval Between Onset and Death | |
| | | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | |
| | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | |
| | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | |
| | | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | |
| | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| | | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of injury (Month, Day, Year) | | 28b. Time of injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | | 28d. Describe how injury occurred | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | |
| | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| | | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Certifying Physician: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| | | 29b. Signature and title of certifier  Paul Valle MD | | 29c. License number D26835 | | 29d. Date signed (Month, Day, Year) December 22, 1997 | | | |
| | | 30. Name and address of person who completed cause of death (other than 23e) (Type, Print) P.A. Valle MD 1012 Nt. Pt. Rd. Balto. MD. 21224 | | | | | | | |
| | | 31. Date filed (Month, Day, Year) DEC 24 1997 | | | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Item 41 per MEO Film G754 12-24-97 rja

Certificate of Death

Reg. No.

97 38934

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Bertha C. PEARMAN

2. Date of Death

Nov 23 97 1442

3. Time of Death

Funeral
Director

4a. Facility Name (If not institution, give street and number)

7900 BENICH APT. 830

4b. City, Town, or Location of Death

GLEN BURNIE

4c. County of Death

AA

5. Social Security Number

220-14-7850A

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

90 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

JUNE 23, 1907

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

A. A. COUNTY

10c. City, Town or Location

GLEN BURNIE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

7900 BENICH CIRCLE

10f. Zip Code

21061

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: BLACK

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

1-4 YRS

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

LPN

16b. Kind of Business/Industry

SELF-EMPLOYED

17. Father's Name (First, Middle, Last)

CHARLES A.

18. Mother's Name (First, Middle, Maiden Surname)

LILLIE HOGAN

19a. Informant's Name/Relationship (Type, Print)

CLAYTON GREENE (SON)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7795 FREETOWN RD. GLEN BURNIE, MD. 21060

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

HALLS CHURCH CEMETERY 11-28-97 GLEN BURNIE, MD.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

JOSEPH H. BROWN JR. FUNERAL HOME, P.A.

22. Name and Address of Facility

2140 N. FULTON AVE., BALTIMORE, MD. 21217

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Arteriosclerotic Heart Disease UNK.

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

William P. Jones, MD Deputy

29c. License number

D06054

29d. Date signed (Month, Day, Year)

11/25/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

William P. Jones, MD 695 America A 21035

31. Date filed (Month, Day, Year)

DEC 24 1997

32. Registrar's Signature

Julia Davidson-Randall

State

Registrar

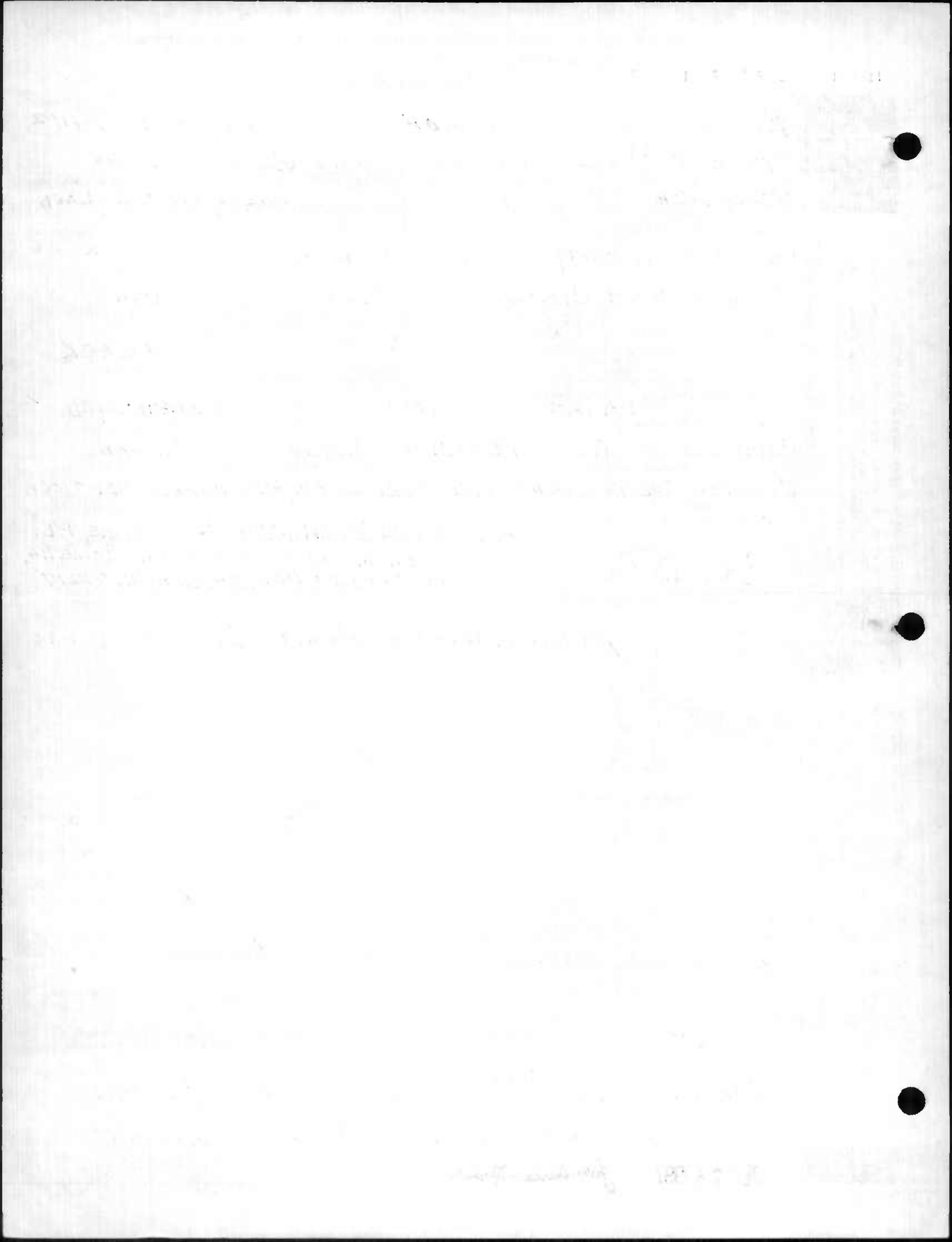
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Reg. No. 97 38935

97 38935

DHHH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38936

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

HASSIE CRAWLEY SMITH

2. Date of Death

December 18 1997 12:18

3. Time of Death

4a. Facility Name (If not institution, give street and number)

UNION MEMOIAL HOSPITAL

4b. City, Town, or Location of Death

BALTO

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

149-14-0760

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

75

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

NOV 27 1922

9. Birthplace (State or Foreign Country)

NC

Usual Residence of Decedent

10a. State
MD

10b. County

N/A

10c. City, Town or Location

BALTO

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

5150 HESPERUS DR

10f. Zip Code

21044

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

if Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No if Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4 or 5+)

2yrs

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

SALES ASSOCIATE

16b. Kind of Business/Industry

DEPT STORE

17. Father's Name (First, Middle, Last)

IVORY CRAWLEY

18. Mother's Name (First, Middle, Maiden Surname)

LILLY PAYLOR

19a. Informant's Name/Relationship (Type, Print)

ROSLYN SMITH

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2301 BAYLEAF CT BALTO, MD 21209

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

BALTIMORE NATIONAL CEM

Date

DEC 23 1997

20c. Location - City or Town, State

BALTO, MD

21. Signature of Funeral Service Licensee

Patricia B...

22. Name and Address of Facility

BETTS FUNERAL HOME
1129 N. CAROLINE ST BALTO, MD 21213

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Cardiac arrest

1 minute

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Respiratory failure

3 weeks

Due to (or as a consequence of):

c. End stage Cancer of the breast

2 years

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural5 ☐ Pending investigation2 ☐ Accident3 ☐ Suicide4 ☐ Homicide6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

B...

29c. License number

AT2438346

29d. Date signed (Month, Day, Year)

December 18, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Bahadur ALSayl MD 201 East University Parkway, Baltimore, MD 21218

31. Date filed (Month, Day, Year)

DEC 24 1997

32. Registrar's Signature

John Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Hassie Crawley Smith
Division of Vital Records, P.O. Box 68760,

10

Handwritten signature

DEC 2 1987

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38937

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Mary C. Smith

2. Date of Death

Month
December 17

Day

Year
1997

3. Time of Death

20:45

4a. Facility Name (If not institution, give street and number)

Johns Hopkins Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

216-60-7157

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

46 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Sept. 11, 1951

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Pasadena

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1673 Twickenham Road

10f. Zip Code

21122

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

N/A

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Secretary

16b. Kind of Business/Industry

Olston Services

17. Father's Name (First, Middle, Last)

Oscar Weinbrenner

18. Mother's Name (First, Middle, Maiden Surname)

Genievieve Erman

19a. Informant's Name/Relationship (Type, Print)

Donald L. Smith Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1673 Twickenham Road Pasadena, Maryland 21122

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Glen Haven Mem. Park Dec. 22, 1997

20c. Location - City or Town, State

Glen Burnie, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

McCully-Polyniak Funeral Home
3204 Mountain Road Pasadena, Maryland 2112223a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. right middle cerebral artery stroke

Approximate
Interval Between
Onset and Death

one week

Due to (or as a consequence of):

b. cerebral abscess

three months

Due to (or as a consequence of):

c. congenital tricuspid atresia

forty-six
years

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

28. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

house officer

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

December 17, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Julie Huang; Tower 110, Johns Hopkins Hospital; Baltimore, Maryland 21287

31. Date filed (Month, Day, Year)

DEC 24 1997

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filled within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit
certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 38938

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

THEDA M. SILLIK

2. Date of Death
Month Day Year
DECEMBER 23 19973. Time of Death
4:42 AM

4a. Facility Name (If not institution, give street and number)

GILCHRIST HOSPICE

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

212-18-9054

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

78 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
June 11 1919

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Md.

10b. County

n/a

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1611 Belt Street

10f. Zip Code

21230

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

white

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

Home Owner

17. Father's Name (First, Middle, Last)

Harry C. Cage

18. Mother's Name (First, Middle, Maiden Surname)

Louisa H. Dawson

19a. Informant's Name/Relationship (Type, Print)

Sandy Antlitz (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

518 S. Rolling Road Baltimore, Md. 21228

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Loudon Park Cemetery

Date

Dec. 27

1997

20c. Location - City or Town, State

Baltimore, Md.

21. Signature of Funeral Service Licensee

Daniel A. Nayle

22. Name and Address of Facility

McCully-Polyniak Funeral Home

130 E. Fort Ave. Baltimore, Md. 21230

23a. Pert I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. end-stage obstructive lung disease

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 year

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) Hospice

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation2 ☐ Accident3 ☐ Suicide4 ☐ Homicide6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

H. Anthony Riley, MD

29c. License number

025205

29d. Date signed (Month, Day, Year)

December 23, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

W. A. Riley & BMC 6701 N. Charles St. Balto. md 21204

31. Date filed (Month, Day, Year)

DEC 24 1997

32. Registrar's Signature

John Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be signed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38939

| | | | | | | | | | | |
|--|---|--------------------------|---|---|--|--|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Sonia M. Schilling | | | | | | 2. Date of Death Month Day Year December 23, 1997 | | 3. Time of Death 11:00 am | |
| | 4a. Facility Name (If not institution, give street and number) Franklin Woods Center | | | | | | 4b. City, Town, or Location of Death Rosedale | | 4c. County of Death Baltimore | |
| Funeral Director | 5. Social Security Number 213-32-9268 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 62 Yrs. | | 8. Date of Birth (Month, Day, Year) 12-13-35 | | 9. Birthplace (State or Foreign Country) Maryland | |
| | Usual Residence of Decedent | | | | | | | | | |
| 10a. State Maryland | | 10b. County Baltimore | | 10c. City, Town or Location Rosedale | | | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| 10e. Street and Number 6715 Havenoak Road Apt B 3 | | | | | | 10f. Zip Code 21237 | | 10g. Citizen of What Country? USA | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 2 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Accountant | | | 16b. Kind of Business/Industry Bookkeeping | | | |
| 17. Father's Name (First, Middle, Last) Zachary Janiuk | | | | | | 18. Mother's Name (First, Middle, Maiden Surname) Mary UNK. | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Karen W. Gniazdowski / Niece | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 443 Drew Street Baltimore, Md 21224 | | | | |
| 20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory | | Date 12/26 | | 20c. Location - City or Town, State Baltimore, Md | | |
| 21. Signature of Funeral Service Licensee | | | | | | 22. Name and Address of Facility Cvach/Rosedale Funeral Home 1211 Chesaco Ave. Balto, Md 21237 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. <u>Metastatic Breast Cancer</u> Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ | | | | | | | | | | Approximate Interval Between Onset and Death 4 years. |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | |
| | | | | | | | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| | | | | 28d. Describe how injury occurred | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | |
| | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | 29b. Signature and title of certifier | | | | 29c. License number D18487 | | |
| | | | | 29d. Date signed (Month, Day, Year) 12/23/97 | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MYO THANT 6830 HOSPITAL DRIVE, BALTO, MD 21237 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 24 1997 | | | | 32. Registrar's Signature | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that this death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

State
Registrar

REF. 4-371
JAN 1964

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38940

| | | | | | | | | |
|---|--|--|---|--|--|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Ada B. Sheets | | | | 2. Date of Death Month Day Year December 22 1997 | | 3. Time of Death 4:10 AM | |
| | 4a. Facility Name (If not institution, give street and number) Johns Hopkins Bayview Medical Center | | | | 4b. City, Town, or Location of Death Baltimore | | 4c. County of Death N/A | |
| Funeral Director | 5. Social Security Number 217-18-1828 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 91 Yrs. | | 8. Date of Birth (Month, Day, Year) May 11, 1906 | |
| | 9. Birthplace (State or Foreign Country) West Virginia | | 10a. State Maryland | | 10b. County Baltimore | | 10c. City, Town or Location Dundalk | |
| To Be Completed by Funeral Director | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 10e. Street and Number 4115 Old North Point Road | | 10f. Zip Code 21222 | | 10g. Citizen of What Country? United States | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6 Years | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Press Operator | | 16b. Kind of Business/Industry Manufacturing | | 17. Father's Name (First, Middle, Last) James Stout | |
| | 18. Mother's Name (First, Middle, Maiden Surname) Naomi Burrows | | 19a. Informant's Name/Relationship (Type, Print) Delcie Dyes / Daughter | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4115 Old North Pt. Road Dundalk, Maryland 21222 | | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | |
| Physician /Medical Examiner | 20b. Place of Disposition (Name of cemetery, crematory or other place) Meadowridge Mem. Park Cem. | | 20c. Date 12/24/97 | | 20d. Location - City or Town, State Elkridge, MD | | 21. Signature of Funeral Service Licensee <i>Chad W. Lutz</i> | |
| | 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Killup IV Non Q wave Myocardial Infarction Due to (or as a consequence of): b. Ischemic Cardiomyopathy Due to (or as a consequence of): c. Coronary Artery Disease Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | Approximate Interval Between Onset and Death 1 day | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | |
| To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | |
| | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| To Be Completed by Physician/Medical Examiner | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | |
| | 29b. Signature and title of certifier <i>SP/100, M.D.</i> | | 29c. License number 97029 | | 29d. Date signed (Month, Day, Year) 12-22-97 | | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Esther P.J. Von der Wal JHBMC 4940 Eastern Ave Balt, MD 21224 | |
| State Registrar | 31. Data filed (Month, Day, Year) DEC 24 1997 | | 32. Registrar's Signature <i>Julia Davidson-Randall</i> | | 33. Date of Death December 22 1997 | | 34. Time of Death 4:10 AM | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38941

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit.Physician
/Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

| | | | | | |
|---|--|--|--|---|--|
| 1. Decedent's Name (First, Middle, Last) LILLIAN P. TOBIN | | 2. Date of Death Month Dec. Day 20 Year 1997 | | 3. Time of Death 10:25 PM | |
| 4a. Facility Name (If not institution, give street and number) Stella Maris Hospice | | 4b. City, Town, or Location of Death Timonium | | 4c. County of Death Baltimore | |
| 5. Social Security Number 217-22-6671 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 74 Yrs. | |
| 8. Date of Birth (Month, Day, Year) Aug. 24, 1923 | | 9. Birthplace (State or Foreign Country) Md. | | | |
| 10a. State Md. | | 10b. County Baltimore | | 10c. City, Town or Location Towson | |
| 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number 904 Fairway Dr. | | 10f. Zip Code 21286 | |
| 10g. Citizen of What Country? USA | | 11. Marital Status <input type="checkbox"/> Navar Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | |
| 13. Was Decedent of Hispanic Origin? (Specify Yes or No) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 Collega (1-4 or 5+) Home maker | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Home maker | | 16b. Kind of Business/Industry Own home | |
| 17. Father's Name (First, Middle, Last) Frank Pac | | 18. Mother's Name (First, Middle, Maiden Surname) Anna Lewandowski | | | |
| 19a. Informant's Name/Relationship (Type, Print) Robert J. Mueller/nephew | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6 Dixie Dr. Towson, Md. 21204 | | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) Entombment | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Lorraine Park Cemetery | | 20c. Location - City or Town, State 12/23/97 Baltimore, Md. | |
| 21. Signature of Funeral Service Licensee | | 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. METASTATIC LUNG CA Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | | | | |
| 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input checked="" type="checkbox"/> Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | |
| 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | |
| 29b. Signature and title of certifier | | 29c. License number 033215 | | 29d. Date signed (Month, Day, Year) 12/22/97 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Shirley Thompson-Richards 100 West Rd. Towson, Md. 21204 | | | | | |
| 31. Date filed (Month, Day, Year) DEC 24 1997 | | 32. Registrar's Signature | | | |

[Faint, illegible text covering the page, possibly bleed-through from the reverse side.]

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38942

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

George Henry Washington

2. Date of Death

Month Day Year
December 23, 1997

3. Time of Death

1:30a.m.

4a. Facility Name (If not institution, give street and number)

916 Frog Mortar Road

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

216-01-8380

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

85 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Aug. 4, 1912

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

916 Frog Mortar Road

10f. Zip Code

21220

10g. Citizen of What Country?

United States

11. Marital Status

☐ Never Married ☐ Married
☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
☐ Yes ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

1

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Engineer

16b. Kind of Business/Industry

Defense Electronics

17. Father's Name (First, Middle, Last)

Alfred Washington

18. Mother's Name (First, Middle, Maiden Surname)

Clara Mae Etzel

19a. Intendant's Name/Relationship (Type, Print)

Michael Washington/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

916 Frog Mortar Road, Baltimore, MD 21220

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Green Mount Crematory

Date

12-24-97

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

Stephen D. Lohrmann

22. Name and Address of Facility

CAFA - Stephen D. Lohrmann, P.A.

8717 Green Pastures Dr., Baltimore, MD 21286

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. RESPIRATORY FAILURE

Due to (or as a consequence of):

f. PNEUMONIA

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

g. CHRONIC OBSTRUCTIVE LUNG DISEASE

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☒ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient☐ ER/Outpatient☐ DOA

Other:

☒ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural
☐ Accident
☐ Suicide
☐ Homicide☐ Pending Investigation
☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?
☐ Yes ☒ No

28e. Place of Injury - At home, farm, street, tectory, office building, etc. (Specify)

28d. Describe how Injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and Title of Certifier

Peter P. Stamas

29c. License number

D25538

29d. Date signed (Month, Day, Year)

12/24/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Peter P. STAMAS MD 6565 N. CHARLES ST. #402 BALTIMORE MD 21204

31. Date filed (Month, Day, Year)

DEC 24 1997

32. Registrar's Signature

Julia Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

87 38943

| | | | | | | | | | | |
|--|---|---|--|---|--|--|---|--|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Patricia Emily Wannall | | | | 2. Date of Death Month December Day 23 , Year 1997 | | | | 3. Time of Death 7:20am | |
| | 4a. Facility Name (If not institution, give street and number) Pleasant Living Nursing Home | | | | 4b. City, Town, or Location of Death Edgewater | | | | 4c. County of Death Anne Arundel | |
| Funeral Director | 5. Social Security Number 578-05-6788 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 86 Yrs. | | 8. Date of Birth (Month, Day, Year) Mar. 17, 1911 | | 9. Birthplace (State or Foreign Country) Washington, DC | |
| | Usual Residence of Decedent | | | | 10a. Street and Number 5547 Franklin Blvd. | | | | 10b. Zip Code 20733 | |
| 10e. State MD | | 10f. County Anne Arundel | | 10c. City, Town or Location Churchton | | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker | | 16b. Kind of Business/Industry Own Home | | | | | | |
| 17. Father's Name (First, Middle, Last) Clarence James Russell | | | | 18. Mother's Name (First, Middle, Maiden Surname) Emily M. Richards | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Donna Patricia Cullember-Daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5547 Franklin Blvd. Churchton, MD 20733 | | | | | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory | | Date 12/24 | | 20c. Location - City or Town, State Baltimore, MD | | | | |
| 21. Signature of Funeral Service Licensee Thomas A. Hardesty | | | | 22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Ave. Annapolis, MD 21401 | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Cardiopulmonary arrest Due to (or as a consequence of): Diabetes mellitus Due to (or as a consequence of): hypoglycemia Due to (or as a consequence of): Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 2 hrs years 2 months | | | | Approximate Interval Between Onset and Death 2 hrs years 2 months | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | |
| | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how Injury occurred | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and Title of certifier Rona Chess MD | | 29c. License number D48101 | | 29d. Date signed (Month, Day, Year) 12/23/97 | | | | |
| Name and address of person who completed causa of death (Item 23a) (Type, Print) 7 Chambers MD 1833A Forest Dr Annapolis MD | | | | | | | | | | |
| Month, Day, Year DEC 24 1997 | | 32. Registrar's Signature Julia Davidson-Randall | | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68768

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

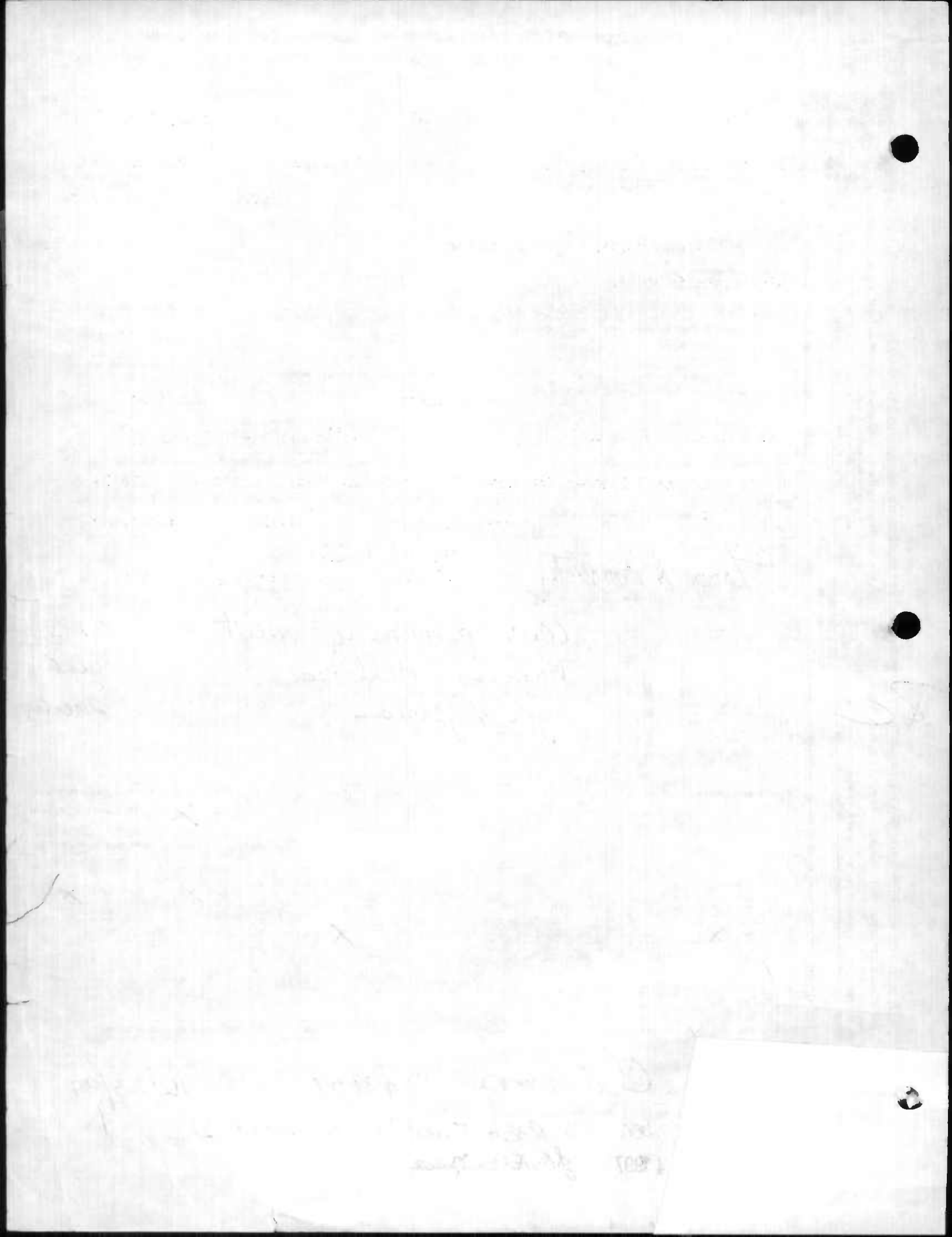
Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38944

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

James H. Anderson

2. Date of Death
Month Day Year

November 29, 1997

3. Time of Death

8:27 A.M.

4a. Facility Name (If not institution, give street and number)

Anne Arundel Medical Center

4b. City, Town, or Location of Death

Annapolis

4c. County of Death

Anne Arundel

Funeral
Director

5. Social Security Number

579-07-4666

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

80

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth
(Month, Day, Year)

July 11, 1917

9. Birthplace (State or Foreign Country)

Washington, DC

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Edgewater

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2112 Shore Drive

10f. Zip Code

21037

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: 1941-45

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Salesman

16b. Kind of Business/Industry

Paper

17. Father's Name (First, Middle, Last)

James Anderson

18. Mother's Name (First, Middle, Maiden Surname)

Florence Long

19a. Informant's Name/Relationship (Type, Print)

Mary Vakas/ Friend

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2112 Shore Drive Edgewater, Maryland 21037

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metropolitan Crematory 12-1-97

Date

20c. Location - City or Town, State

Alexandria, Virginia

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

George P. Kalas Funeral Home

2973 Solomons Island Rd. Edgewater, Md. 21037

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. Renal Failure

1 month

Due to (or as a consequence of):

b. Diabetes Mellitus

10 years

Due to (or as a consequence of):

c. Hypertension

10 years

Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA

28. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined28a. Date of Injury
(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D38129

29d. Date signed (Month, Day, Year)

12-1-97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Vincent Chen, M.D. 9131 Piscataway Rd. Suite 600 Clinton, Maryland 20735

31. Date filed (Month, Day, Year)

DEC 02 1997

32. Registrar's Signature

John Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38945

| | | | | | | | | | | | |
|--|--|----------------------------------|---|---|--|--|---|--|---|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) EDITH AVRILL | | | | | | 2. Date of Death Month Day Year DECEMBER 2, 1997 | | 3. Time of Death 1:28 am | | |
| | 4a. Facility Name (If not institution, give street and number) HOLY CROSS HOSPITAL | | | | | | 4b. City, Town, or Location of Death SILVER SPRING | | 4c. County of Death MONTGOMERY | | |
| Funeral Director | 5. Social Security Number 439-03-6834 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 85 Yrs. | | 8. Date of Birth (Month, Day, Year) MAY 5, 1912 | | 9. Birthplace (State or Foreign Country) HOUSTON TEXAS | | |
| | Usual Residence of Decedent | | | | | | | | | | |
| 10a. State MD | | 10b. County MONTGOMERY | | 10c. City, Town or Location SILVER SPRING | | | | 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | |
| 10e. Street and Number 12325 NEW HAMPSHIRE AVE | | | | 10f. Zip Code 20904 | | | 10g. Citizen of What Country? USA | | | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: BLACK | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Collage (1-4or 5+) 2 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) PRACTICAL NURSE | | | | 16b. Kind of Business/Industry MEDICAL | | | |
| 17. Father's Name (First, Middle, Last) EMMITT TAYLOR | | | | | | 18. Mother's Name (First, Middle, Maiden Surname) CATHERINE ALLEN | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) HERMAN TAYLOR/NEPHEW | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17505 COUNTRY VIEW WAY ASHTON MD 20861 | | | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) GEORGE WASHINGTON CEMETERY 12-8-97 ADELPHI MD | | | Date | | 20c. Location - City or Town, State | | |
| 21. Signature of Funeral Service Licensee Alex S. Pope Jr | | | | | | 22. Name and Address of Facility ALEXANDER S. POPE FUNERAL HOMES 5538 MARLBORO PIKE FORESTVILLE MD 20743 | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. ACUTE MYOCARDIAL INFARCTION Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | | | | | | | | | Approximate Interval Between Onset and Death ~ 1 hr | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | |
| | | | | | | | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. Certifier (Check only one) 2 <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | |
| 29b. Signature and title of certifier M. S. Nayar | | | | | | 29c. License number D-17874 | | 29d. Date signed (Month, Day, Year) 12-3-97 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S.M. NAYAR, M.D. 3717-38th AVE COTTAGE CITY, MD 20817 | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 08 1997 | | | | 32. Registrar's Signature John M. ... | | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

38946

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Lee Pershing Ayres

2. Date of Death

Month Day Year
December 4, 1997

3. Time of Death

4:50 am

4a. Facility Name (If not Institution, give street and number)

Prince George's Hospital Center

4b. City, Town, or Location of Death

Cheverly

4c. County of Death

Prince George's

Funeral
Director

5. Social Security Number

217-40-0134

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

55

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

April 23, 1942

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10e. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Riverdale

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

6326 67th Court

10f. Zip Code

20737

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give
Year or Dates: 1975-7713. Was Decedent of Hispanic Origin? (Specify Yes or No -
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Maintenance Supervisor

16b. Kind of Business/Industry

Local Government

17. Father's Name (First, Middle, Last)

John Pershing Ayres

18. Mother's Name (First, Middle, Maiden Surname)

Hazel Lucille Coons

19e. Informant's Name/Relationship (Type, Print)

Lucille E. Ayres - Spouse

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6326 67th Court, Riverdale, Maryland 20737

20e. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Fort Lincoln Cemetery

Date

12/09/97

20c. Location - City or Town, State

Brentwood, Maryland

21. Signature of Funeral Service Licensee

Claudette S. Dooch

22. Name and Address of Facility

Francis Gasch's Sons Funeral Home, P.A.
4739 Baltimore Avenue, Hyattsville, MD 2078123e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

e.

MYOCARDIAL INFARCTION

Due to (or as a consequence of):

b.

CORONARY ARTERY DISEASE

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Approximate
Interval Between
Onset and Death

5 MIN.

10 YEARS

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☒ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
2 ☐ Accident investigation
3 ☐ Suicide 6 ☐ Could not be
4 ☐ Homicide determined

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

M

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Mark Parkhurst

29c. License number

D24093

29d. Date signed (Month, Day, Year)

12/5/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

MARK PARKHURST MD 7305 BALT. AVE #107 COLLEGE PARK MD.

31. Date filed (Month, Day, Year)

DEC 08 1997

32. Registrar's Signature

John Anderson

State
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Charles Arthur Bell

2. Date of Death

November 24, 1997

Day

3. Time of Death

8:45 AM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

NORTH ARUNDEL HOSPITAL

4b. City, Town, or Location of Death

GLEN BURNIE

4c. County of Death

ANNE ARUNDEL

5. Social Security Number

213-82-9084

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

62 Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

8. Date of Birth

(Month, Day, Year)

Mar. 16, 1935

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Pasadena

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

724 210th Street

10f. Zip Code

21122

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify:

white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

N/A

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

N/A

16b. Kind of Business/Industry

N/A

17. Father's Name (First, Middle, Last)

Unknown

18. Mother's Name (First, Middle, Maiden Surname)

Ellen Bell

19a. Informant's Name/Relationship (Type, Print)

Carolyn Collini

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

628 George Avenue, Baltimore, MD 21221

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Old Holy Family Church Cem. 11-26-97 Randallstown, MD

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

► *Robert S. Bell*

22. Name and Address of Facility

Barranco and Sons P.A. Funeral Home
495 Ritchie Hwy. Severna Park, MD 21146

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CONGESTIVE HEART FAILURE

Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

► *Arthur*

MD

29c. License number

D435177

29d. Date signed (Month, Day, Year)

November 24 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

CYNTHIA DRETLING, 301 HOSPITAL DRIVE Glen Burnie MD 21061.

31. Date filed (Month, Day, Year)

DEC 01 1997

32. Registrar's Signature

*John Davidson-Randall*State
Registrar

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38948

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

Sta
Registr

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38949

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

RUTH VIRGINIA BUTLER

2. Date of Death

Month NOV Day 29 Year 1997

3. Time of Death

1955pm

4a. Facility Name (If not institution, give street and number)

NATIONAL NAVAL MEDICAL CENTER BETHESDA

4b. City, Town, or Location of Death

BETHESDA

4c. County of Death

MONTGOMERY CO.

Funeral
Director

5. Social Security Number

214-66-0394

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

89 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
June 10 1908

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

Charter House 1316 Fenwick Ln #524

10f. Zip Code

20910

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16e. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Bookkeeper

16b. Kind of Business/Industry

United States Naval
Academy Athletic Assoc.

17. Father's Name (First, Middle, Last)

William Hayden

18. Mother's Name (First, Middle, Maiden Surname)

Sue Weber

19e. Informant's Name/Relationship (Type, Print)

Barbara L. Scott (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9912 Belhaven Road Bethesda, Maryland 20817

20e. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Arlington National Cemetery 12/3/97 Arlington, Virginia

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

John M. Taylor Funeral Home, Inc.
147 Duke of Gloucester St. Annapolis, MD 2140123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

e. PANCREATITIS WITH PENETRATION

Due to (or as a consequence of):

b. UGI BLEED

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation
6 ☐ Could not be determined28e. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury at
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28d. Describe how injury occurred
28f. Location (Street and Number or Rural Route Number,
City or Town, State)29e. Certifier
(Check only
one)1 ☒ Certifying Physician2 ☐ Medical ExaminerTo the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner as stated.

29b. Signature and title of

D. DEKERATRY, T. MC. USN

29c. License number

RES - 000

29d. Date signed (Month, Day, Year)

NOV 30 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

D. DEKERATRY, LT. MC. USN NATIONAL NAVAL MEDICAL CENTER, BETHESDA, MD 20889

31. Date filed (Month, Day, Year)

DEC 04 1997

32. Registrar's Signature

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23e-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

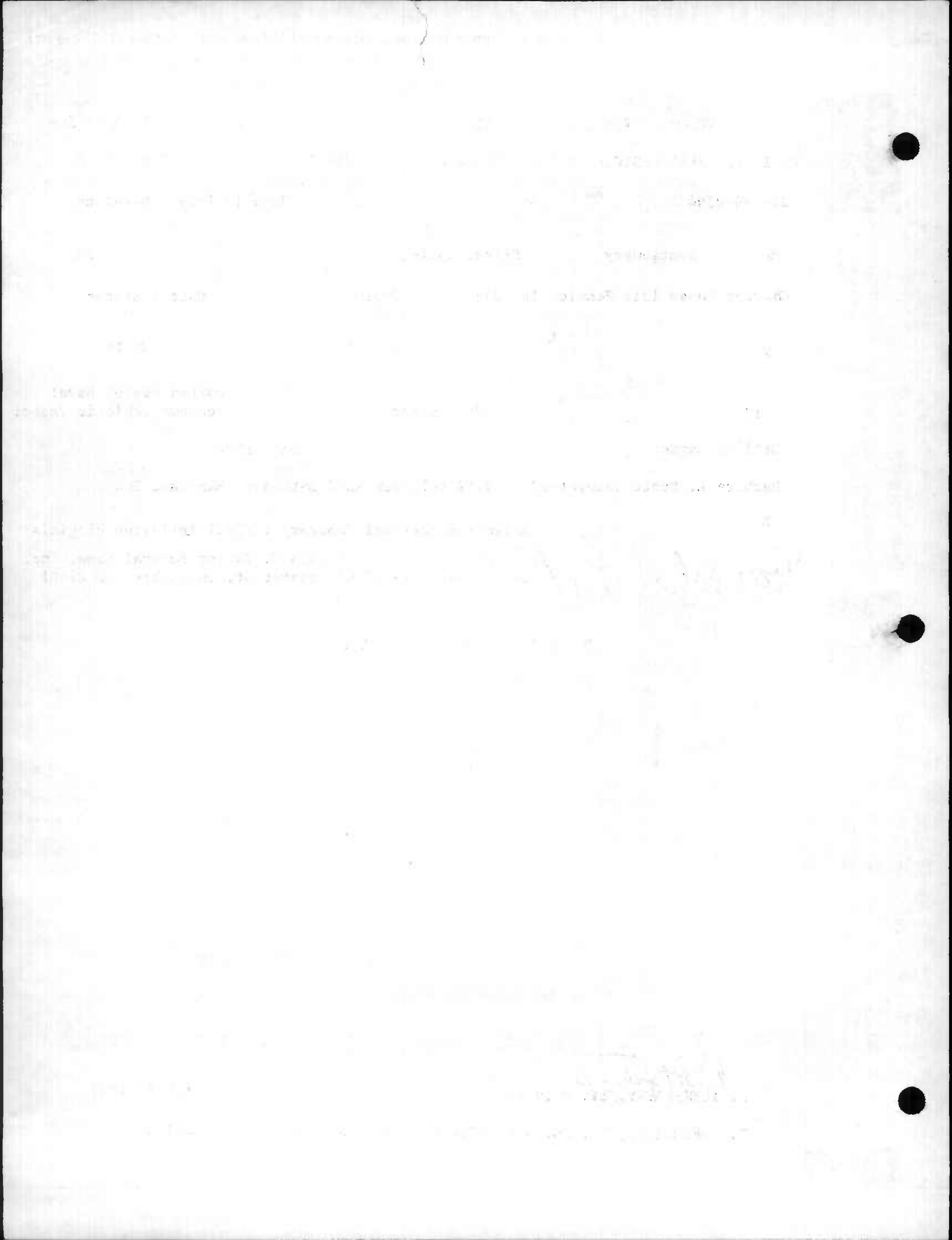
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

37 38950

| | | | | | | | | | |
|--|---|---|---|---|--|---|---|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) JANE M. BOYD | | | | 2. Date of Death Month Day Year 12 - 2 - 1997 | | 3. Time of Death 12:05 PM | | |
| | 4a. Facility Name (If not institution, give street and number) ANNE ARUNDEL GENERAL HOSPITAL | | | | 4b. City, Town, or Location of Death ANNAPOLIS | | 4c. County of Death ANNE ARUNDEL | | |
| Funeral Director | 5. Social Security Number 220-03-5635 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 85 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) DEC. 10, 1911 | 9. Birthplace (State or Foreign Country) MARYLAND | |
| | Usual Residence of Decedent | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State MARYLAND | 10b. County ANNE ARUNDEL | | 10c. City, Town or Location ANNAPOLIS | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | 10e. Street and Number 1313 WEST STREET | | | 10f. Zip Code 21401 | | 10g. Citizen of What Country? U.S.A. | | | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (14 or 5+) N/A | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER | | 16b. Kind of Business/Industry OWN HOME | | | |
| | 17. Father's Name (First, Middle, Last) PHILIP A. MYERS | | | | 18. Mother's Name (First, Middle, Maiden Surname) EMMA B. OTTO | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) WILLIAM E. BOYD (SON) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 214 NASHUA COURT, GAMBRILLS, MD. 21054 | | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify): | | 20b. Place of Disposition (Name of cemetery, crematory or other place) CEDAR HILL | | Data 12/5/97 | | 20c. Location - City or Town, State BROOKLYN, MARYLAND | | |
| | 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility SINGLETON FUNERAL HOME, 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061 | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. DEHYDRATION Due to (or as a consequence of): b. MENTAL STATUS CHANGES Due to (or as a consequence of): c. ALZHEIMER'S DISEASE Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter underlying cause (Disease or injury that initiated events resulting in death) Last Approximate Interval Between Onset and Death 1 week 1 week 5 years | | | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes mellitus, Acute | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier | | 29c. License number D11653 | | 29d. Date signed (Month, Day, Year) Dec. 2, 1997 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Peter VERKOUW MD 2003 Med. Parkway, ANNAPOLIS, MD, 21401 | | | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 04 1997 | | 32. Registrar's Signature | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

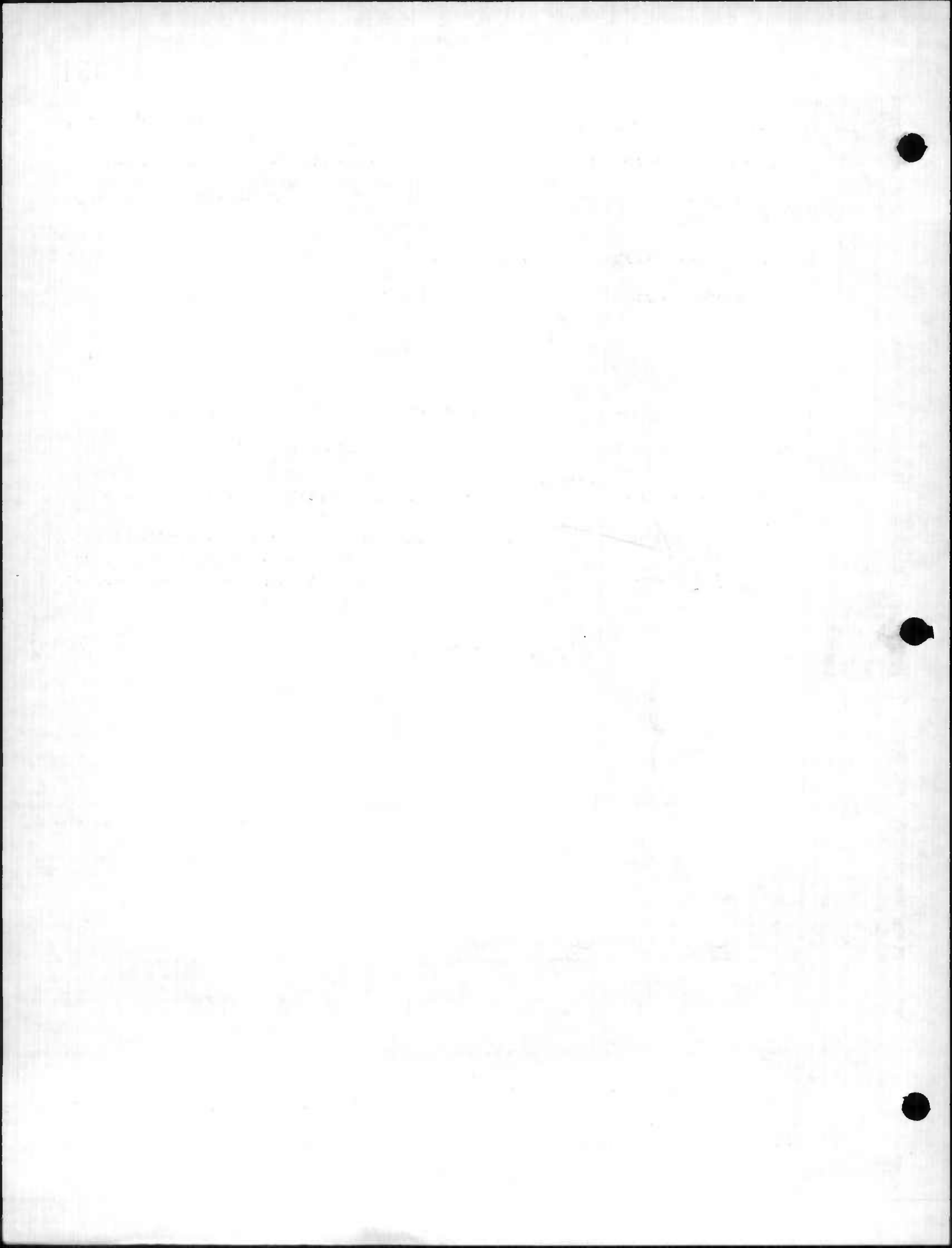
Reg. No.

97 38951

| | | | | | | | | |
|--|---|-------------------------------|---|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) NELDA MAE BAUMGARDNER | | | | 2. Date of Death Month 11 - Day 30 - Year 1997 | | 3. Time of Death 6 A.M. | |
| | 4a. Facility Name (If not institution, give street and number) NORTH ARUNDEL HOSPITAL | | | | 4b. City, Town, or Location of Death GLEN BURNIE | | 4c. County of Death ANNE ARUNDEL | |
| Funeral Director | 5. Social Security Number 212-28-2408 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 67 Yrs. | | 8. Date of Birth (Month, Day, Year) 08-10-1930 | |
| | 10a. State MARYLAND | | 10b. County ANNE ARUNDEL | | 10c. City, Town or Location GLEN BURNIE | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| To Be Completed by Funeral Director | 10e. Street and Number 7625 FRANCIS ROAD | | | | 10f. Zip Code 21060 | | 10g. Citizen of What Country? U.S.A. | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 YEARS College (1-4 or 5+) ----- | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER | | 16b. Kind of Business/Industry OWN HOME | | | |
| | 17. Father's Name (First, Middle, Last) FRANK JOSEPH HARRISON | | | | 18. Mother's Name (First, Middle, Maiden Surname) SADIE R. HULETT | | | |
| | 19a. Informant's Name/Relationship (Type, Print) VERONICA L. KOCH-KELLY (DAUGHTER) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7820 MALLOW CT. PASADENA, MARYLAND 21122 | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) CEDAR HILL CEMETERY | | Date 12-3-97 | | 20c. Location - City or Town, State BALTIMORE, MARYLAND | |
| | 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility THE SINGLETON FUNERAL HOME 1 SECOND AVE. S.W. GLEN BURNIE, MARYLAND 21061 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Emphysema Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | |
| | 24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 28d. Describe how Injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| State Registrar | 29b. Signature and title of certifier | | | | 29c. License number 018508 | | 29d. Date signed (Month, Day, Year) 12-3-97 | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles J. Wu, M.D. 1600 South Crain Highway Glen Burnie MD. 21061 | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 04 1997 | | 32. Registrar's Signature | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

37 38952

| | | | | | | | | |
|--|---|--|--|---|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Isabelle E. Brezna | | | | 2. Date of Death Month 12 Day 03 Year 1997 | | 3. Time of Death 9:10 PM | |
| | 4a. Facility Name (If not institution, give street and number) 1119 Revolution Street | | | | 4b. City, Town, or Location of Death Havre de Grace | | 4c. County of Death Harford | |
| Funeral Director | 5. Social Security Number 179-14-3262 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 91 Yrs. | | 8. Date of Birth (Month, Day, Year) 09/03/1906 | |
| | 9. Birthplace (State or Foreign Country) PA | | 10a. State MD | | 10b. County Harford | | 10c. City, Town or Location Havre de Grace | |
| 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number 1119 Revolution St | | 10f. Zip Code 21078 | | 10g. Citizen of What Country? USA | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Seamstress | | 16b. Kind of Business/Industry Clothing | | | | |
| 17. Father's Name (First, Middle, Last) Joseph Switoyus | | 18. Mother's Name (First, Middle, Maiden Surname) Anna Kazlauskas | | 19a. Informant's Name/Relationship (Type, Print) James J. Brezna- Son | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6207 S. Osborne Rd. Upper Marlboro, MD 20772 | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) R.A. Ferris & Co. Inc. | | 20c. Location - City or Town, State 12/5/97 West Chester, PA | | | | |
| 21. Signature of Funeral Service Licensee <i>George M. Hampton Jr</i> | | 22. Name and Address of Facility Mitchell-Smith Funeral home, P.A. 123 S. Washington St. Havre de Grace, MD | | 23a. Pertinent disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. e. <i>cerebral thrombosis</i> Due to (or as a consequence of): b. <i>cerebral arteriosclerosis</i> Due to (or as a consequence of): c. <i>hypertensive cerebro-vascular disease</i> Due to (or as a consequence of): d. <i>Cardiac Failure</i> | | Approximate interval Between Onset and Death | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | |
| 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier <i>James H. Wo...</i> | | 29c. License number D 15491 | | 29d. Date signed (Month, Day, Year) 12/4/97 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 407 S. Union Ave Havre de Grace, MD | | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 5 1997 | | 32. Registrar's Signature <i>John A. Randall</i> | | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38953

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ARL WOODROW BROCK

2. Date of Death

Month Day Year
December 1 1997

3. Time of Death

9:24 PM

4a. Facility Name (If not institution, give street and number)

Fallston General Hospital

4b. City, Town, or Location of Death

Fallston

4c. County of Death

Harford

Funeral
Director

5. Social Security Number

234-26-5513

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

77 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
April 15, 1920

9. Birthplace (State or Foreign Country)

W. Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Harford

10c. City, Town or Location

Pylesville

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

1147 Old Pylesville Rd.

10f. Zip Code

21132

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☒ Yes ☐ No
If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
8

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Mechanic

16b. Kind of Business/Industry

US Government

17. Father's Name (First, Middle, Last)

Gilbert Lawrence Brock

18. Mother's Name (First, Middle, Maiden Surname)

Nancy Cyle Wamsley

19a. Informant's Name/Relationship (Type, Print)

Gladys E. Brock - wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1147 Old Pylesville Rd., Pylesville, MD 21132

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Garrison Forest Cemetery

Date

12-5-97

20c. Location - City or Town, State

Owings Mill, MD

21. Signature of Funeral Service Licensee

Stephen C. Hughes

22. Name and Address of Facility

Howard K. McComas III Funeral Home, P.A.
1317 Cokesbury Rd., Abingdon, MD 21009

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of death.

Immediate Cause (Final disease or condition resulting in death)

a. Acute Myocardial Infarction

Approximate Interval Between Onset and Death

2 hours

Due to (or as a consequence of):

b. Hypertension

15 yrs

Due to (or as a consequence of):

c. Hyperlipidemia

15 yrs

Due to (or as a consequence of):

d. Cerebrovascular Accident

1 yr

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☐ Probably ☒ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

28. Place of Death (Check only one)

Hospital:

☐ Inpatient

☐ ER/Outpatient

☒ DOA

Other:

☐ Nursing Home

☐ Residence

☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending Investigation
☐ Accident ☐ Could not be determined
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Stephen C. Hughes MD

29c. License number

036715

29d. Date signed (Month, Day, Year)

DECEMBER 3, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SHERIF H. OSMAN 39 CHURCHVILLE ROAD BEL AIR, MD 21014

31. Date filed (Month, Day, Year)

DEC 4 1997

32. Registrar's Signature

Stephen C. Hughes

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

37 38954

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician
/Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | | | | |
|---|--|---|---|---|--------------------------------|--|--|
| 1. Decedent's Name (First, Middle, Last) SYLVIA BEATRICE BLEVINS | | | | 2. Date of Death Month Day Year Dec. 8, 1997 | | 3. Time of Death 3:10 AM | |
| 4a. Facility Name (If not institution, give street and number) 4125 Little Rd. | | | | 4b. City, Town, or Location of Death Whiteford | | 4c. County of Death Harford | |
| 5. Social Security Number 212-50-2768 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 87 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) April 19, 1910 | |
| 9. Birthplace (State or Foreign Country) Virginia | | | | | | | |
| Usual Residence of Decedent | | 10a. State Maryland | | 10b. County Harford | | 10c. City, Town or Location Whiteford | |
| 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 10e. Street and Number 4125 Little Rd. | | 10f. Zip Code 21160 | | 10g. Citizen of What Country? USA | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker | | 16b. Kind of Business/Industry Own Home | | | |
| 17. Father's Name (First, Middle, Last) George Emory Covington Tickle | | | | 18. Mother's Name (First, Middle, Maiden Surname) Sallie Vermillion Hughes | | | |
| 19a. Informant's Name/Relationship (Type, Print) Brenda J. Richardson - Daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4125 Little Rd., Whiteford, Md. 21160 | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Bel Air Memorial Gardens | | 20c. Date 12-11-97 | | 20d. Location - City or Town, State Bel Air, Maryland | |
| 21. Signature of Funeral Service Licensee Holly K. McComas | | | | 22. Name and Address of Facility Howard K. McComas III Funeral Home, P.A. 50 W. Broadway St., Bel Air, MD 21014 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>acute cerebrovascular accident</i> Due to (or as a consequence of): b. <i>arteriosclerotic cardiovascular disease</i> Due to (or as a consequence of): c. <i>insulin dependent diabetes mellitus</i> Due to (or as a consequence of): d. Approximate Interval Between Onset and Death <i>days</i> <i>years</i> <i>years</i> | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>congestive heart failure</i> <i>osteoporosis; degenerative joint disease</i> <i>multiple episodes of trauma</i> | | | | | | | |
| 25. Was cause referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. Signature and title of certifier Herbert A. Martello | | | | 29c. License number M-7320 | | 29d. Date signed (Month, Day, Year) 12/08/97 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HERBERT A. MARTELLO | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 9 1997 | | | | 32. Registrar's Signature [Signature] | | | |

State
Registrar

Handwritten notes, possibly a list or series of entries, written in cursive script.

Handwritten notes, possibly a list or series of entries, written in cursive script.

Handwritten notes, possibly a list or series of entries, written in cursive script.

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|--|---|--|---|---|---|--|---|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) IDA BORUM | | | | 2. Date of Death Month December Day 6 Year 1997 | | 3. Time of Death 11:15AM | |
| | 4a. Facility Name (If not institution, give street and number) Holy Cross Hospital | | | | 4b. City, Town, or Location of Death Silver Spring | | 4c. County of Death Montgomery | |
| Funeral Director | 5. Social Security Number 578-20-9922 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 84 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) NOV 26, 1913 | 9. Birthplace (State or Foreign Country) South Carolina |
| | Usual Residence of Decedent | | | | 10c. City, Town or Location Washington, D.C. | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10a. State N/A | | 10b. County N/A | | 10e. Street and Number 716 12th Street S.E. #22 | | 10f. Zip Code 20003 | | 10g. Citizen of What Country? United States |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Black | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Dietician | | 16b. Kind of Business/Industry Private | | |
| 17. Father's Name (First, Middle, Last) Edward Glover | | | | 18. Mother's Name (First, Middle, Maiden Surname) Ida Mae Burton | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Ruth Threadgill /Daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1101 Kennebec St #613, Oxon Hill, MD. 20745 | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Harmony Memorial Cemetery | | Date 12/13/97 | | 20c. Location - City or Town, State Landover, Maryland |
| 21. Signature of Funeral Service Licensee Alex S Pope Jr | | | | 22. Name and Address of Facility M859 ALEXANDER S. POPE FUNERAL HOMES 2617 Pennsylvania Avenue, SE DC 20020 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Urosepsis | | | | | | | | Approximate Interval Between Onset and Death 73 Days |
| Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of): | | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. Due to (or as a consequence of): | | | | | | | | |
| c. Due to (or as a consequence of): | | | | | | | | |
| d. Due to (or as a consequence of): | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Peripheral vascular Disease | | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) N/A | | 28b. Time of Injury N/A | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred N/A |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) N/A | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) N/A | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier Rahul Gilotra | | | | 29c. License number D32417 | | 29d. Date signed (Month, Day, Year) December 6th, 1997 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RAHUL GILOTRA, MD 12016 GEORGIA Avenue Wheaton, MD 20902 | | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 11 1997 | | | | 32. Registrar's Signature J. A. Anderson-Randall | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

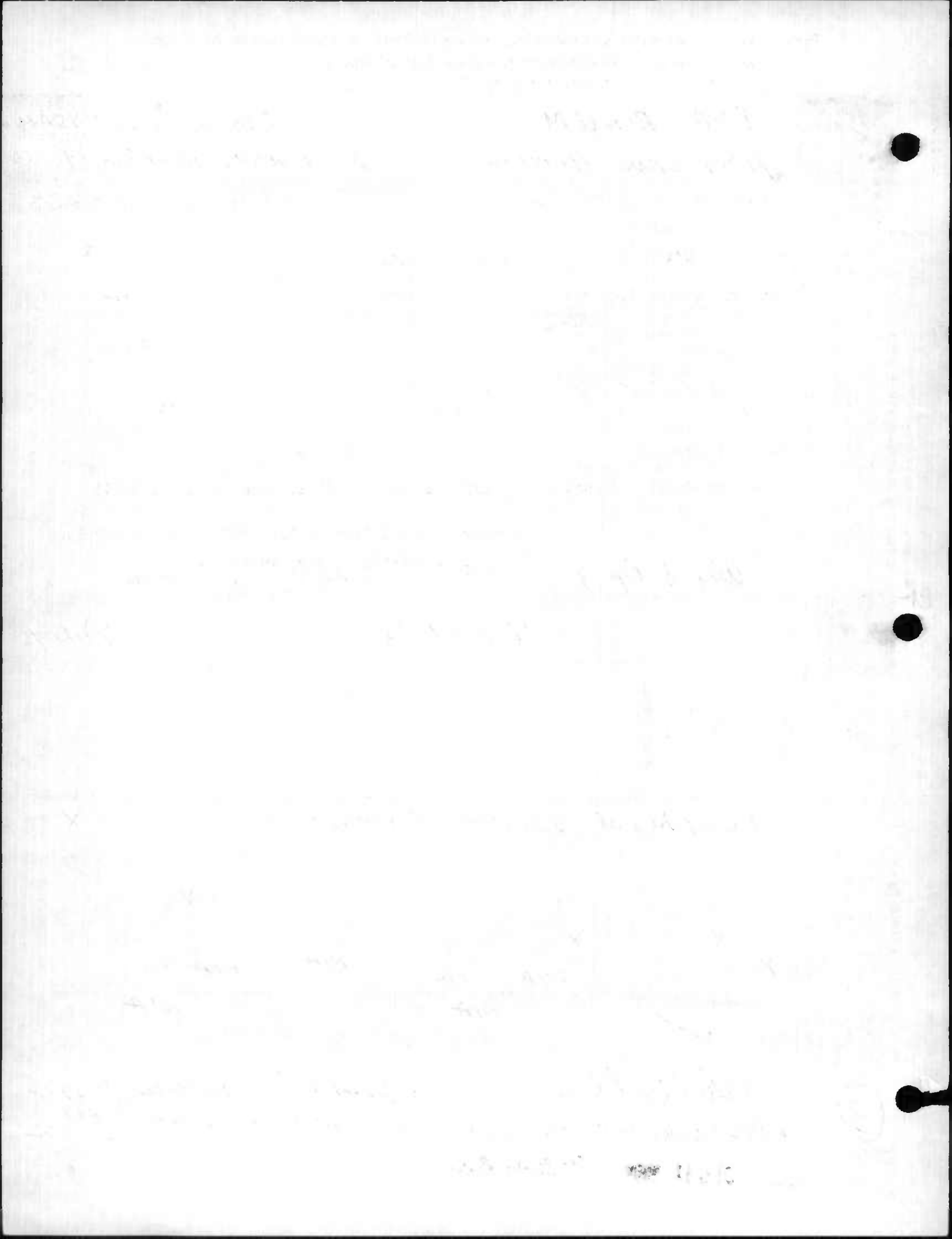
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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38956

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

WILLIAM HENRY BOYD

2. Date of Death

Month Day Year
DECEMBER 6, 1997

3. Time of Death

2:15am

Funeral
Director

4a. Facility Name (If not institution, give street and number)

P.G. HOSPITAL

4b. City, Town, or Location of Death

CHEVERLY MD

4c. County of Death

P.G. COUNTY

5. Social Security Number

310-12-0716

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

74 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

DECEMBER 19, 1922 CHARLESTOWN IN

9. Birthplace (State or Foreign Country)

Usual Residence of Decedent

10a. State

MD

10b. County

P.G. COUNTY

10c. City, Town or Location

CAPITOL HEIGHTS

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

48 BAYOU AVE

10f. Zip Code

20743

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: BLACK

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

FEDERAL PROTECTIVE OFFICER

16b. Kind of Business/Industry

GOVERNMENT

17. Father's Name (First, Middle, Last)

JOHN WESLEY BOYD

18. Mother's Name (First, Middle, Maiden Surname)

LILLIE BELL JACKSON

19a. Informant's Name/Relationship (Type, Print)

MARTHA BOYD /WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

48 BAYOU AVE CAPITOL HEIGHTS MD 20743

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☒ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

CHARLESTOWN CEMETERY

Date

12-13-97

20c. Location - City or Town, State

CHARLESTOWN INDIANA

21. Signature of Funeral Service Licensee

Alyx S. Pope Jr

22. Name and Address of Facility

ALEXANDER S. POPE FUNERAL HOMES
5538 MARLBORO PIKE FORESTVILLE MD 20743

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cardiorespiratory arrest
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

24 hours

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Cerebrovascular accident
Due to (or as a consequence of):

72 hours

c. Cerebral thrombosis
Due to (or as a consequence of):

72 hours

d. Hypertensive disease.
Due to (or as a consequence of):

10 years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes mellitus - 6 years

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

V. P. Chandan MD

29c. License number

D16380

29d. Date signed (Month, Day, Year)

12.8.97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

V. Prem Chandan - 6001 Landover Rd Chevy MD 20785

31. Date filed (Month, Day, Year)

DEC 11 1997

32. Registrar's Signature

Ski Anderson

State
Registrar

Baltimore, Maryland 21215-0020

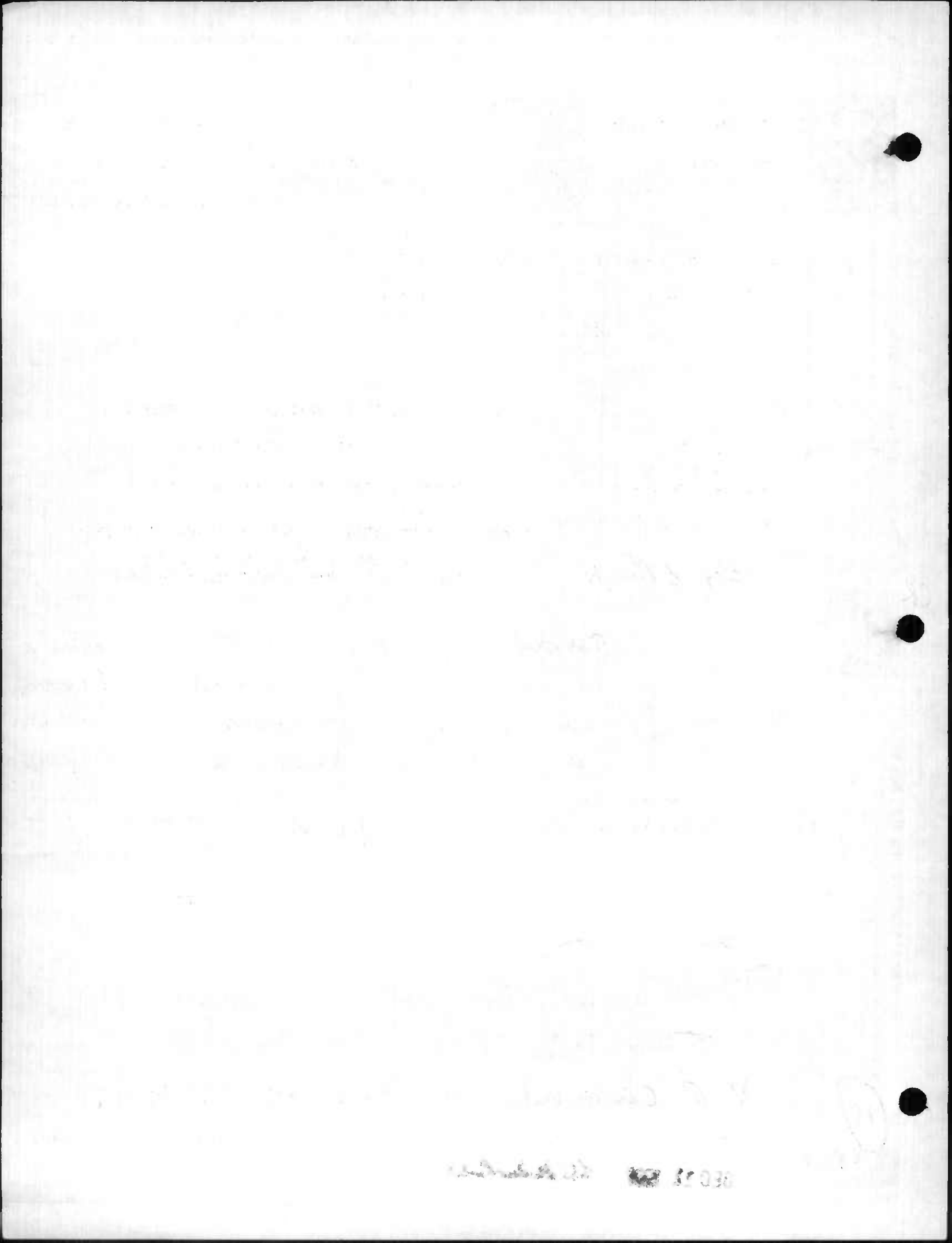
Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 38957

Certificate of Death

Reg. No.

| | | | | | | | | | | | | |
|--|---|--|---|--|---|--|---|--|--|--|-----------------------------------|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Margaret Eva Barnhart | | | | 2. Date of Death December 9 th 1997 | | | | 3. Time of Death 6:00A.M. | | | |
| | 4a. Facility Name (If not institution, give street and number) 2601 Holly Drive | | | | 4b. City, Town, or Location of Death Ft. Washington | | | | 4c. County of Death Prince George's | | | |
| Funeral Director | 5. Social Security Number 160-07-1305 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 79 Yrs. | | 8. Date of Birth (Month, Day, Year) 11-16-1918 | | 9. Birthplace (State or Foreign Country) Pennsylvania | | | |
| | Usual Residence of Decedent | | | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State Maryland | | 10b. County Prince George's | | 10c. City, Town or Location Fort Washington | | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | |
| | 10e. Street and Number 2601 Holly Drive | | | | 10f. Zip Code 20744 | | | | 10g. Citizen of What Country? USA | | | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: White | | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker | | | | 16b. Kind of Business/Industry At Home | | | |
| | 17. Father's Name (First, Middle, Last) Paul M. Weidman | | | | | | 18. Mother's Name (First, Middle, Maiden Surname) Eva M. Tschudy | | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) Omar F. Barnhart/Husband | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2601 Holly Dr., Ft. Washington, MD 20744 | | | | | | | |
| | 20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory | | | | 20c. Location - City or Town, State Alexandria, Virginia | | 20d. Date 12/9/97 | |
| | 21. Signature of Funeral Service Licensee <i>George P. Kalas</i> | | | | 22. Name and Address of Facility George P. Kalas Funeral Home 6160 Oxon Hill Rd., Oxon Hill, MD 20745 | | | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>Respiratory Distress</i> Due to (or as a consequence of): b. <i>Chronic Obstructive Pulmonary Disease</i> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | | | | | | | | |
| | 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | |
| | 29b. Signature and title of certifier <i>R. M. Nedzela</i> | | | | 29c. License number DC-7348 | | | | 29d. Date signed (Month, Day, Year) Dec 9, 1997 | | | |
| State Registrar | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) R. M. NEDZELA MD 11701 L'ANGLAIS RD. FORT WASH MD 20744 | | | | | | | | | | | |
| | 31. Date filed (Month, Day, Year) DEC 10 1997 | | | | 32. Registrar's Signature <i>John A. ...</i> | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

37 38958

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ESTHER

P.

Bradsher

2. Date of Death

Month

Day

Year

December 8 1997

3. Time of Death

0651

Funeral
Director

4a. Facility Name (If not institution, give street and number)

SHADY GROVE ADVENTIST HOSPITAL

4b. City, Town, or Location of Death

ROCKVILLE

4c. County of Death

MONTGOMERY

5. Social Security Number

517-22-0744

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

74

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

Apr. 10, 1923

9. Birthplace (State or Foreign Country)

Montana

Usual Residence of Decedent

10a. State

Virginia

10b. County

Fairfax

10c. City, Town or Location

Annandale

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

4408 Island Place # 102

10f. Zip Code

22003

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever In U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Security Officer

16b. Kind of Business/Industry

Federal Government

17. Father's Name (First, Middle, Last)

Niels Petersen

18. Mother's Name (First, Middle, Maiden Surname)

Otilia (Unknown)

19a. Informant's Name/Relationship (Type, Print)

George Springer, Guardian

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4009 Braddock Rd., Alexandria, VA 22312

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Mt. Comfort Crematory

Date

12/10

20c. Location - City or Town, State

Alexandria, VA

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Demaine Funeral Home

3308 Backlick Road

Springfield, VA 22151

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)a. Acute respiratory failure
Due to (or as a consequence of):

1 day

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Lastb. Hyperosmolar nonketotic diabetic coma
Due to (or as a consequence of):

2 days

c. Diabetes mellitus type 1
Due to (or as a consequence of):

years

d. Cardio myopathy
Due to (or as a consequence of):

years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypotension

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending
investigation6 ☐ Could not be
determined28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Charles W. Karesh, MD

29c. License number

D21726

29d. Date signed (Month, Day, Year)

December 8, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Charles Karesh, MD 8421 Harker Dr., Potomac, MD 20854

31. Date filed (Month, Day, Year)

DEC 10 1997

32. Registrar's Signature

John M. ...

State
Registrar

Baltimore, Maryland 21215-0020

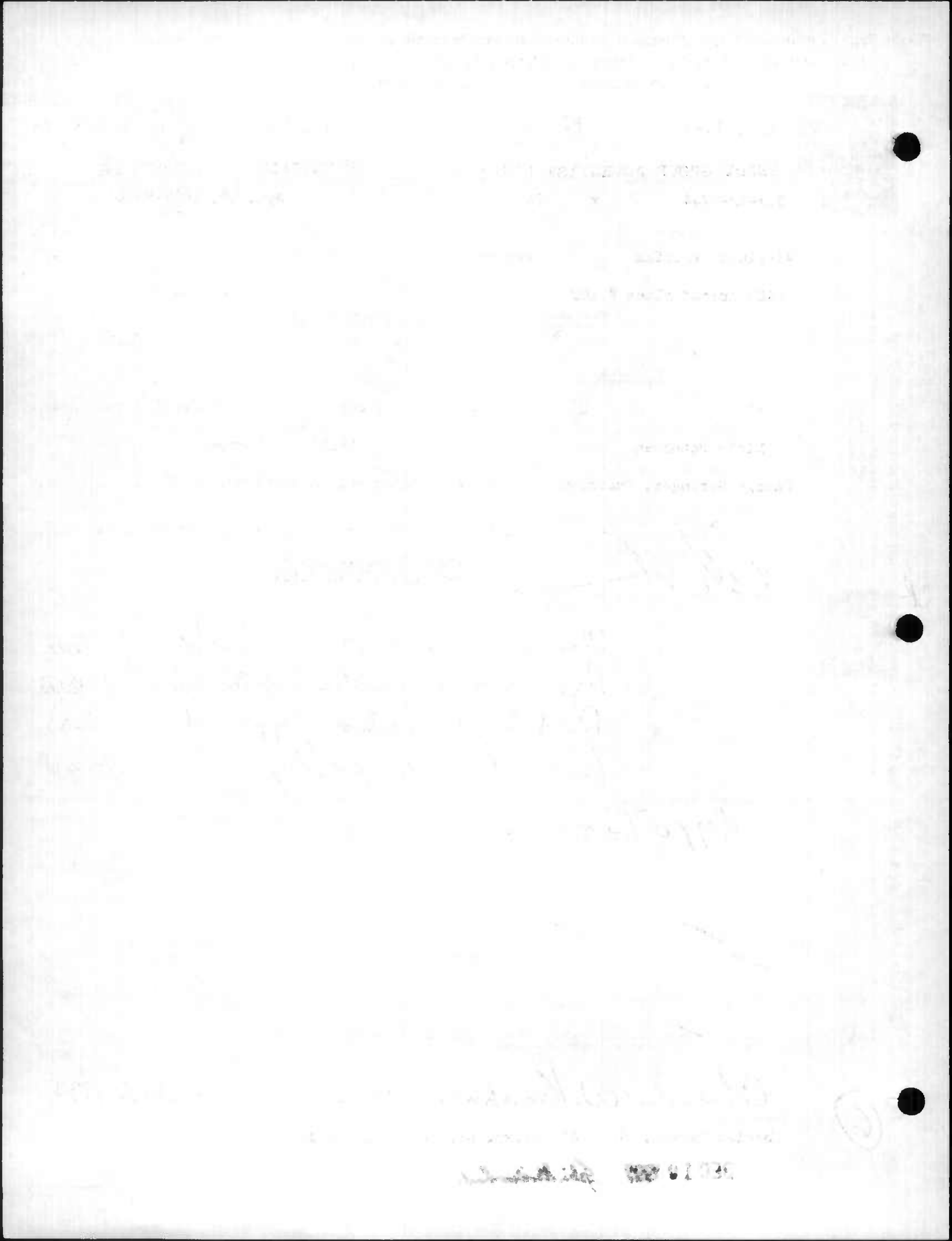
Division of Vital Records, P.O. Box 68760,

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To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



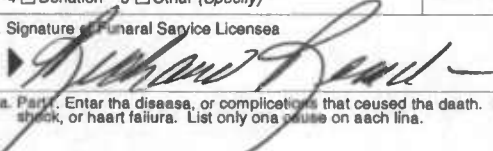
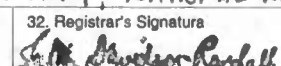
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

87 38959

| | | | | | | | | | | | | | | | | | |
|--|--|---|--|--|---|---------------------------------|--------------------------------|--|--|-----------------------------------|--|--|---|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) David Clinton Bundy | | | | 2. Date of Death Month December Day 5 , Year 1997 | | | | 3. Time of Death 2:30 PM | | | | | | | | |
| | 4a. Facility Name (If not Institution, give street and number) 9504 Sheridan St. | | | | 4b. City, Town, or Location of Death Seabrook | | | | 4c. County of Death Prince Georges | | | | | | | | |
| Funeral Director | 5. Social Security Number 287-09-6768 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 80 Yrs. | | If Under 1 Year Months Days | | If Under 24 Hrs. Hours Min. | | 8. Date of Birth (Month, Day, Year) Nov. 5, 1917 | | 9. Birthplace (State or Foreign Country) Ohio | | | | |
| | Usual Residence of Decedent | | | | | | | | | | | | | | | | |
| 10a. State Maryland | | 10b. County Prince Georges | | 10c. City, Town or Location Seabrook | | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | |
| 10e. Street and Number 9504 Sheridan St. | | | | 10f. Zip Code 20706 | | | | 10g. Citizen of What Country? U.S.A. | | | | | | | | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WWII | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: White | | | | | | | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 Collage (1-4or 5+) 2 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Cryptograph Analyst | | | | 16b. Kind of Business/Industry National Sec. Agency | | | | | | | | | |
| 17. Father's Name (First, Middle, Last) Henry Bundy | | | | 18. Mother's Name (First, Middle, Maiden Surname) Millie News | | | | | | | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Marion S. Bundy (Wife) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9504 Sheridan St. Seabrook, Maryland 20706 | | | | | | | | | | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Arlington National Cemetery | | Data 12/11/97 | | 20c. Location - City or Town, State Arlington, Virginia | | | | | | | | | |
| 21. Signature of Funeral Service Licensee  | | | | 22. Name and Address of Facility Remon/Hale Funeral Home | | | | 9013 Annapolis Rd. Lanham, Maryland 20706 | | | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. METASTATIC COLON CANCER Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | | | | | | | | | | | Approximate Interval Between Onset and Death 1 YEAR | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | |
| | | | | | | | | | | | | 24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) HOSPICE | | | | | | | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred | | | | | | | |
| | | | | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | | | 29b. Signature and title of certifier Daniel L. Brown SURGERY RESIDENT | | 29c. License number CALIFORNIA GFE 79711 | | 29d. Date signed (Month, Day, Year) DECEMBER 9, 1997 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DEPARTMENT OF SURGERY, NATIONAL NAVAL MEDICAL CENTER, BETHESDA, MD 20889 | | | | | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 10 1997 | | | | 32. Registrar's Signature  | | | | | | | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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Physician
/Medical
Examiner

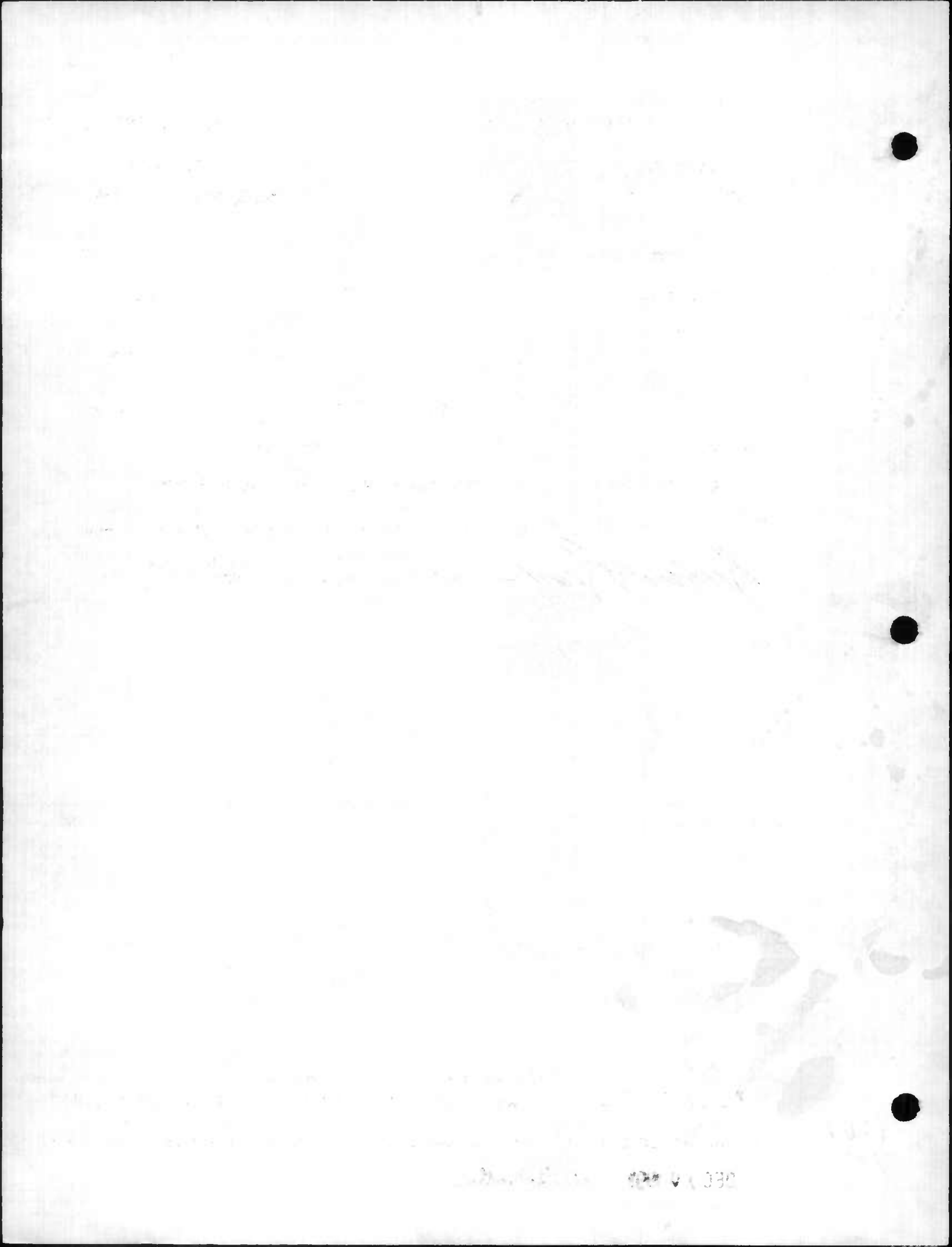
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To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38960

Physician
/Medical
Examiner

Funeral
Director

| | | | | | | | |
|---|--|---|--|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last) ISAAC J BARRETT | | | | 2. Date of Death Month Dec. Day 7 Year 1997 | | 3. Time of Death 6:15 pm | |
| 4a. Facility Name (If not institution, give street and number) Southern Maryland Hospital Clinton | | | | 4b. City, Town, or Location of Death Clinton | | 4c. County of Death Prince Georges | |
| 5. Social Security Number 241-70-7151 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 51 Yrs. | | 8. Date of Birth (Month, Day, Year) October 4, 1946 | |
| 9. Birthplace (State or Foreign Country) North Carolina | | | | | | | |
| Usual Residence of Decedent | | | | | | | |
| 10a. State Maryland | | 10b. County Prince George's | | 10c. City, Town or Location Suitland | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10e. Street and Number 4721 Hudson Avenue Apt. A3 | | | | 10f. Zip Code 20746 | | 10g. Citizen of What Country? U.S.A. | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Black | |
| 15. Decedent's Education (Specify only highest grade completed) 8th grade | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Laborer | | 16b. Kind of Business/Industry N/A | |
| 17. Father's Name (First, Middle, Last) Aubrey Barrett | | | | 18. Mother's Name (First, Middle, Maiden Surname) Julia Richardson | | | |
| 19a. Informant's Name/Relationship (Type, Print) Greta Barrett | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4721 Hudson Avenue Apt. A3 Suitland, Maryland 20746 | | | |
| 20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Chesapeake Crematory, Inc. | | Date 12/9/97 | | 20c. Location - City or Town, State Beltsville, Maryland | |
| 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility Rollins Funeral Home, Inc. 4339 Hunt Place, N.E. Washington, D.C. 20019 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last</p> </div> <div style="width: 35%;"> <p>a. Carcinoma of Kidneys Due to (or as a consequence of):</p> <p>b. metastasis to Brain Due to (or as a consequence of):</p> <p>c. metastasis to lungs Due to (or as a consequence of):</p> <p>d.</p> </div> </div> | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | |
| | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. Describe how injury occurred | | | |
| 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| 29b. Signature and title of certifier | | | | 29c. License number D10868 | | 29d. Date signed (Month, Day, Year) Dec. 8, 1997 | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Mohammad F. Taleghani, M.D. 4467 Old Branch Ave. #301 Temple Hills, MD 20748 | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 09 1997 | | | | 32. Registrar's Signature | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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(2)

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38961

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Louis Joe Bates

2. Date of Death

Month Day Year
DEC 7 1997

3. Time of Death

12:40 AM

Funeral
Director

4a. Facility Name (If not Institution, give street and number)

HOLY CROSS HOSPITAL

4b. City, Town, or Location of Death

SILVER SPRING

4c. County of Death

MONTGOMERY COUNTY

5. Social Security Number

382-30-3252

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

62 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
SEPT. 27, 1935

9. Birthplace (State or Foreign Country)

MISSISSIPPI

Usual Residence of Decedent

10e. State

MARYLAND

10b. County

MONTGOMERY COUNTY

10c. City, Town or Location

SILVER SPRING

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

15024 WHITEGATE ROAD

10f. Zip Code

20905

10g. Citizen of What Country?

UNITED STATES

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: BLACK

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

4+

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

LICENSED THERAPIST

16b. Kind of Business/Industry

PRIVATE

17. Father's Name (First, Middle, Last)

WILLIAM BATES

18. Mother's Name (First, Middle, Maiden Surname)

EULA WHITE

19a. Informant's Name/Relationship (Type, Print)

ESTHER J. BATES, WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

15024 WHITEGATE ROAD, SILVER SPRING, MD 20905

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

FORT LINCOLN CEMETERY

Date

12/13/97

20c. Location - City or Town, State

BRENTWOOD, MARYLAND

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

FORT LINCOLN FUNERAL HOME

3401 BLADENSBURG RD., BRENTWOOD, MARYLAND 20722

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)a. cardiovascular heart
Due to (or as a consequence of):Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Lastb. Disease
Due to (or as a consequence of):c. years
Due to (or as a consequence of):d. years
Due to (or as a consequence of):Approximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?
1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient2 ☒ Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

[Signature]

29c. License number

208546

29d. Date signed (Month, Day, Year)

Dec 7 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

John Tumber 8218 Wisconsin Ave Bethesda

31. Date filed (Month, Day, Year)

DEC 09 1997

32. Registrar's Signature

[Signature]

State
Registrar

Baltimore, Maryland 21215-0020

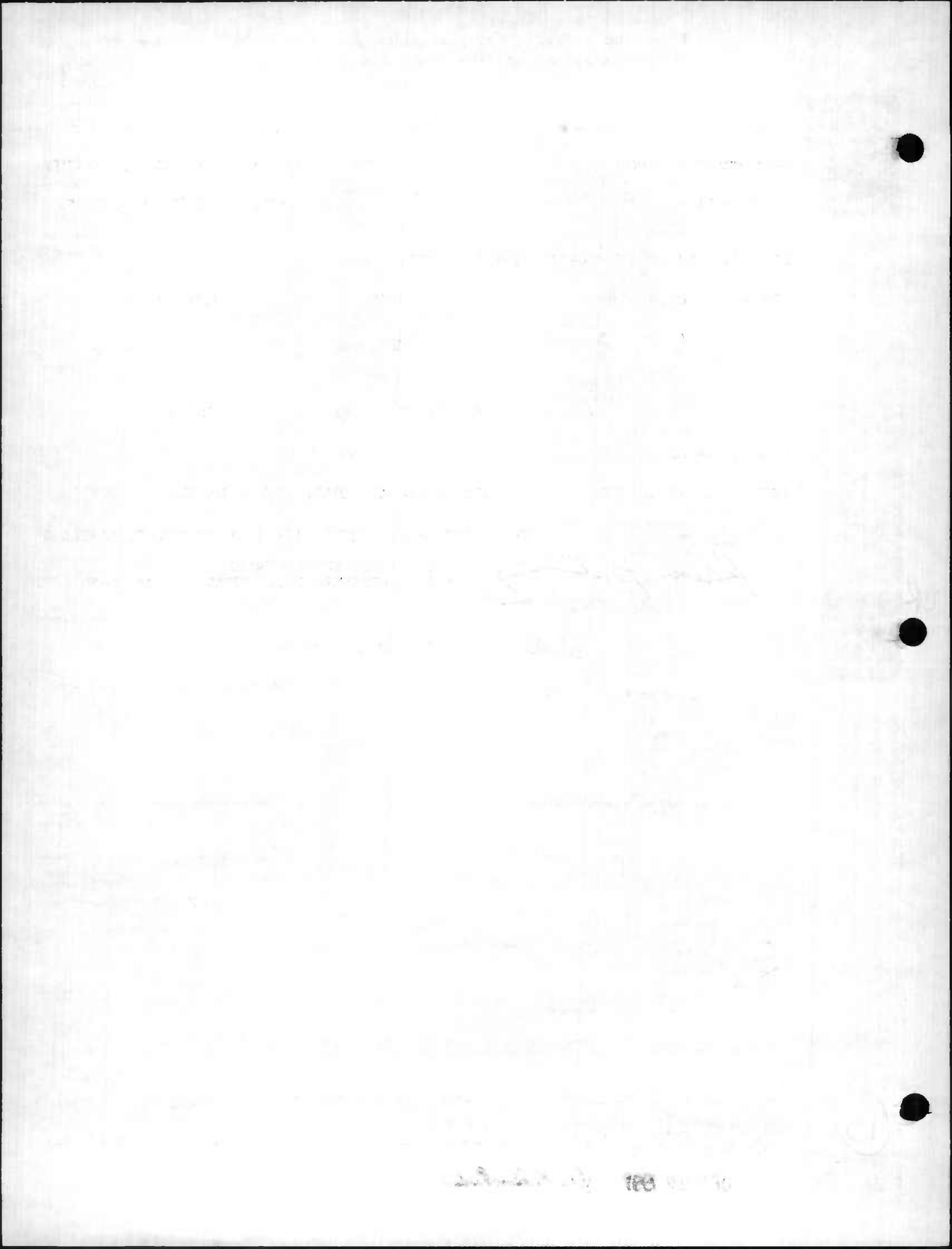
Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

15



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 38962
Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

JAMES Brooks

2. Date of Death

DEC 01 97

3. Time of Death

20:09

4a. Facility Name (If not institution, give street and number)

WASHINGTON ADVENTIST HOSPITAL

4b. City, Town, or Location of Death

Takoma Park

4c. County of Death

MONTGOMERY

Funeral
Director

5. Social Security Number

578-12-5861

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

98

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Nov. 13, 1899

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

10b. County

10c. City, Town or Location

Washington D.C.

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

601 - 18th Street, N.E.

10f. Zip Code

20003

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☐ Married
☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12th

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Carpenter

16b. Kind of Business/Industry

Private Industry

17. Father's Name (First, Middle, Last)

Albert Brooks

18. Mother's Name (First, Middle, Maiden Surname)

Maryah Roy

19a. Informant's Name/Relationship (Type, Print)

Warren Brooks (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6300 Hilmar Dr. #10 Forestville, Md. 20747

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Lincoln Memorial Cemetery Dec. 6, 1997 Suitland, Md.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Ralph Williams

22. Name and Address of Facility

Ralph Williams Funeral Service
517 - 11th Street, SE; Wash., DC

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CONGESTIVE HEART FAILURE 1 wk

Due to (or as a consequence of):

b. DILATED CARDIOMYOPATHY 1 wk

Due to (or as a consequence of):

c. ACUTE TUBULAR NECROSIS 48 HRS

Due to (or as a consequence of):

d. SEVERE HYPOTENSION 72 HRS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital

☒ Inpatient

☐ ER/Outpatient

☐ DOA

Other:

☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending Investigation
☐ Accident ☐ Could not be determined
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature] M.D.

29c. License number

D43772

29d. Date signed (Month, Day, Year)

12/01/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RASAD ABU AD, 7501 SURREY'S ROAD, SUITE 208B, CLINTON MD 20735

31. Date filed (Month, Day, Year)

DEC 08 1997

32. Registrar's Signature

[Signature]

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38963

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Howard C. Bailey

2. Date of Death

Month Day Year
December 5, 1997

3. Time of Death

8:30 P.M.

Funeral
Director

4e. Facility Name (If not institution, give street and number)

Fort Washington Hospital

4b. City, Town, or Location of Death

Fort Washington

4c. County of Death

Prince George's

5. Social Security Number

227-44-1203

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

61

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Dec. 9, 1935

9. Birthplace (State or Foreign Country)

Warsaw, Va.

Usual Residence of Decedent

10a. State

10b. County

10c. City, Town or Location

10d. Inside City Limits

Maryland Prince George's

Ft. Washington

1 ☒ Yes 2 ☐ No

10e. Street and Number

8310 Founders Terrace

10f. Zip Code

20744

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: Black

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
11th

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Bus Driver

16b. Kind of Business/Industry

Touring

17. Father's Name (First, Middle, Last)

Hodi Bailey

18. Mother's Name (First, Middle, Maiden Surname)

Viola Newton

19a. Informant's Name/Relationship (Type, Print)

Rosa Mae Bailey/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Same as item 10

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Cedar Hill Cemetery

Date

12/12/97

20c. Location - City or Town, State

Suitland, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

George P. Kalas Funeral Home
6160 Oxon Hill Rd. Oxon Hill, Md. 2074523a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

e. LIVER FAILURE

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. METASTATIC PANCREATIC CANCER

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury28c. Injury at
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D-20749

29d. Date signed (Month, Day, Year)

12-6-97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jonathan McCone, Jr., M.D. 6196 Oxon Hill Rd. #640, Oxon Hill, Md. 20745

31. Date filed (Month, Day, Year)

DEC 08 1997

32. Registrar's Signature

Sally M. R. R. R.

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

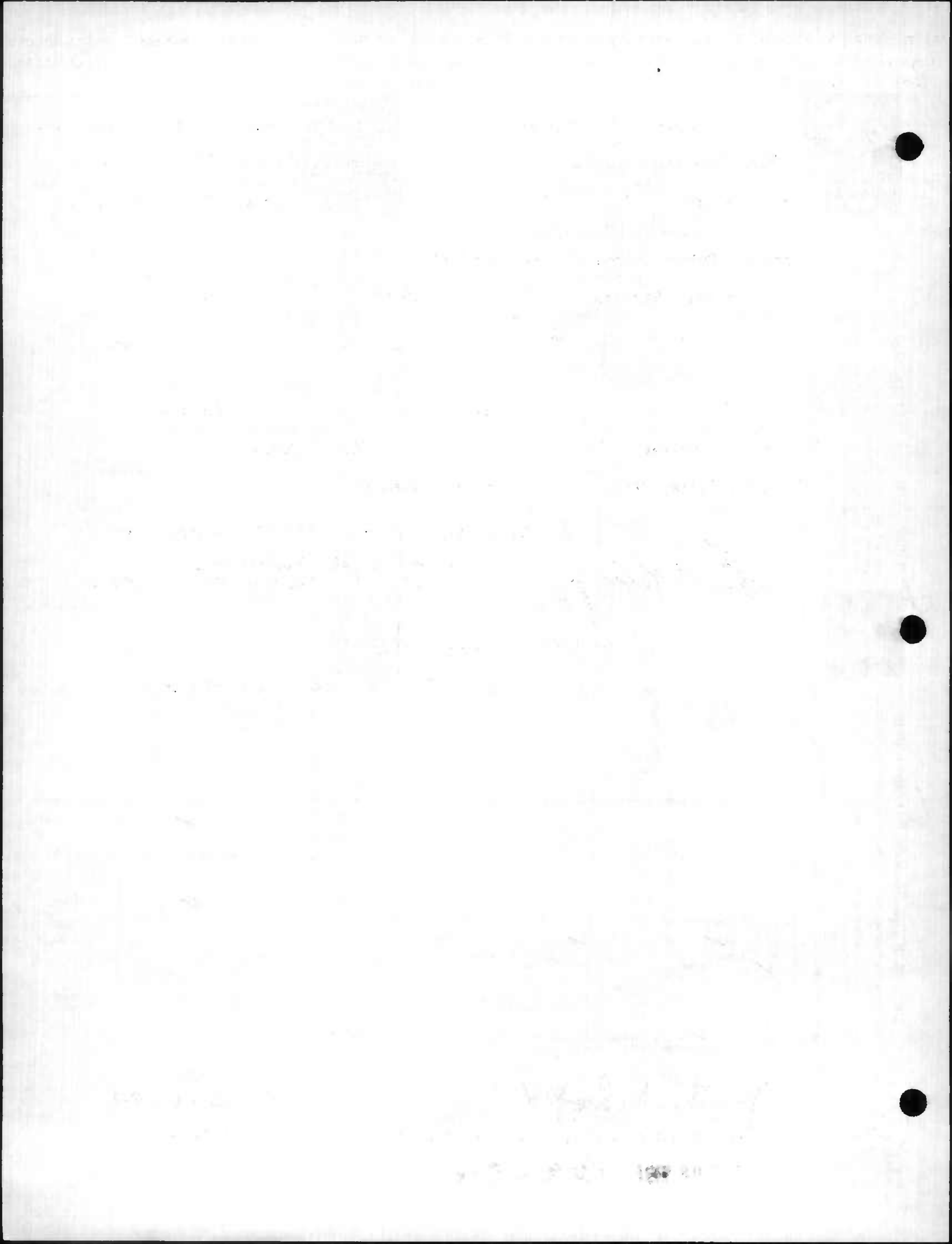
Division of Vital Records, P.O. Box 68760,

to the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
to the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

20



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38964

| | | | | | | | | |
|---|--|----------------------------------|---|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) <i>Virginia Barrett</i> | | | | 2. Date of Death Month <i>December</i> Day <i>5</i> Year <i>1997</i> | | 3. Time of Death <i>6:15 p.m.</i> | |
| | 4a. Facility Name (If not institution, give street and number) <i>Montgomery General Hospital</i> | | | | 4b. City, Town, or Location of Death <i>Olney</i> | | 4c. County of Death <i>Montgomery</i> | |
| Funeral Director | 5. Social Security Number <i>216-07-4366</i> | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) <i>79</i> Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) <i>Nov. 19, 1918</i> | 9. Birthplace (State or Foreign Country) <i>Maine</i> |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State <i>Maryland</i> | | 10b. County <i>Montgomery</i> | | 10c. City, Town or Location <i>Silver Spring</i> | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10e. Street and Number <i>3400 Chiswick Court #1-A</i> | | | | 10f. Zip Code <i>20906</i> | | 10g. Citizen of What Country? <i>U.S.A.</i> | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: <i>White</i> |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Budget Consultant</i> | | | 16b. Kind of Business/Industry <i>D.C. Government</i> | |
| 17. Father's Name (First, Middle, Last) <i>Philip Genthner</i> | | | | | 18. Mother's Name (First, Middle, Maiden Surname) <i>Marjorie Howard</i> | | | |
| 19a. Informant's Name/Relationship (Type, Print) <i>Joanne Dorsey - Daughter</i> | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>1321 Rainbow Drive, Silver Spring, Maryland 20905</i> | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Fort Lincoln Cemetery</i> | | | 20c. Location - City or Town, State <i>12/09/97 Brentwood, Maryland</i> | | |
| 21. Signature of Funeral Service Licensee <i>W.B. Geiss</i> | | | | | 22. Name and Address of Facility <i>Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, MD 20781</i> | | | |
| 23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <i>a. Multiple myeloma</i> Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <i>b. Due to (or as a consequence of):</i> <i>c. Due to (or as a consequence of):</i> <i>d.</i> | | | | | | | | Approximate Interval Between Onset and Death <i>One Year</i> |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| | | | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury <i>M</i> | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| | | | | 28d. Describe how injury occurred | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | |
| | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| 29b. Signature and title of certifier <i>Philip Dr. Olney, MD</i> | | | | | 29c. License number <i>033686</i> | | 29d. Date signed (Month, Day, Year) <i>December 5, 1997</i> | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <i>Kenneth M. ... Prince Philip Dr. Olney, MD</i> | | | | | | | | |
| 31. Date filed (Month, Day, Year) <i>DEC 08 1997</i> | | | | 32. Registrar's Signature <i>...</i> | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38965

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

FREDERICK

2. Date of Death

Month
DEC.Day
5Year
1997

3. Time of Death

2:20AM

4a. Facility Name (If not institution, give street and number)

Washington Adventist Hospital

4b. City, Town, or Location of Death

Takoma Park

4c. County of Death

Montgomery

5. Social Security Number

N/A

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

55 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
08-27-42

9. Birthplace (State or Foreign Country)

West Africa

Usual Residence of Decedent

10e. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Hyattsville

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

7907 14th Avenue #102

10f. Zip Code

20783

10g. Citizen of What Country?

Sierra Leone, West Af.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever In U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: Black

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Pastor

16b. Kind of Business/Industry

Private

17. Father's Name (First, Middle, Last)

Sahr Bona

18. Mother's Name (First, Middle, Maiden Surname)

Yei Jeneh Komonyandeh

19a. Informant's Name/Relationship (Type, Print)

Yei Bayoh/Sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1 Trento Court, Gaithersburg, MD 20877

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Harmony Mem. Park

Date

12/22/97

20c. Location - City or Town, State

Landover, MD

21. Signature of Funeral Service Licensee

Nancy A. Perentis

22. Name and Address of Facility

J. B. Jenkins Funeral Home
7474 Landover Road, Landover, MD 2078523a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

e. Acute Respiratory failure

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

few days

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Mesenteric ischemia

Cerebrovascular accident

Anasarca

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

G. Gupta, MD

29c. License number

D 46398

29d. Date signed (Month, Day, Year)

December, 06, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

G. Gupta, MD 121 congressional Lane, # 409, Rockville, MD 20852

31. Date filed (Month, Day, Year)

DEC 08 1997

32. Registrar's Signature

[Signature]

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit
notice.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38966

| | | | | | | | | | | | | |
|--|---|---|--|---|--|--|--|--|---|-----------------------------------|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) <i>MARY M BARFIELD</i> | | | | 2. Date of Death Month <i>Nov</i> Day <i>30</i> Year <i>1997</i> | | | | 3. Time of Death <i>8:55AM</i> | | | |
| | 4a. Facility Name (If not institution, give street and number) <i>Southern Maryland Hospital</i> | | | | 4b. City, Town, or Location of Death <i>Clinton</i> | | | | 4c. County of Death <i>Prince George's</i> | | | |
| Funeral Director | 5. Social Security Number <i>237 26 3178</i> | | | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) <i>76</i> Yrs. | | 8. Date of Birth (Month, Day, Year) <i>Feb 27, 1921</i> | | 9. Birthplace (State and Foreign Country) <i>NC</i> | |
| | Usual Residence of Decedent | | | | | | | | | | | |
| 10a. State <i>MD</i> | | 10b. County <i>Prince George's</i> | | 10c. City, Town or Location <i>Fort Washington</i> | | | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | |
| 10e. Street and Number <i>6703 Janet Lane</i> | | | | 10f. Zip Code <i>20743</i> | | | | 10g. Citizen of What Country? <i>USA</i> | | | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc. Specify: <i>Black</i> | | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>6</i> College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Custodian</i> | | | | 16b. Kind of Business/Industry <i>Private Contractor</i> | | | | |
| 17. Father's Name (First, Middle, Last) <i>Guy Lyons</i> | | | | | | 18. Mother's Name (First, Middle, Maiden Surname) <i>Annie Hinton</i> | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) <i>Larry Barfield - son</i> | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>4406 Simmons Ln Temple Hills, MD 20748</i> | | | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Ft Lincoln Cemetery</i> | | Date <i>12/6/97</i> | | 20c. Location - City or Town, State <i>Brentwood, MD</i> | | | | |
| 21. Signature of Funeral Service Licensee <i>Nelson E. Green</i> | | | | | | 22. Name and Address of Facility <i>Greene Funeral Home 814 Franklin St Alexandria, VA 22314</i> | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>e. <i>Hypertension</i> Due to (or as a consequence of):</p> <p>b. <i>Seizure disorder</i> Due to (or as a consequence of):</p> <p>c. <i>Pul. Embolism</i> Due to (or as a consequence of):</p> <p>d.</p> </div> <div style="width: 15%;"> <p>Approximate Interval Between Onset and Death</p> <p><i>48h</i></p> <p><i>7d</i></p> <p><i>5d</i></p> </div> </div> | | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | | | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury <i>M</i> | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | | | |
| 29b. Signature and title of certifier <i>L. N. Berwa M.D.</i> | | | | | | 29c. License number <i>D-24535</i> | | 29d. Date signed (Month, Day, Year) <i>11.30.97</i> | | | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <i>L. N. Berwa M.D. 7700 Old Branch Ave., C-101 Clinton, MD 20735</i> | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) <i>DEC 12 1997</i> | | | | 32. Registrar's Signature <i>[Signature]</i> | | | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

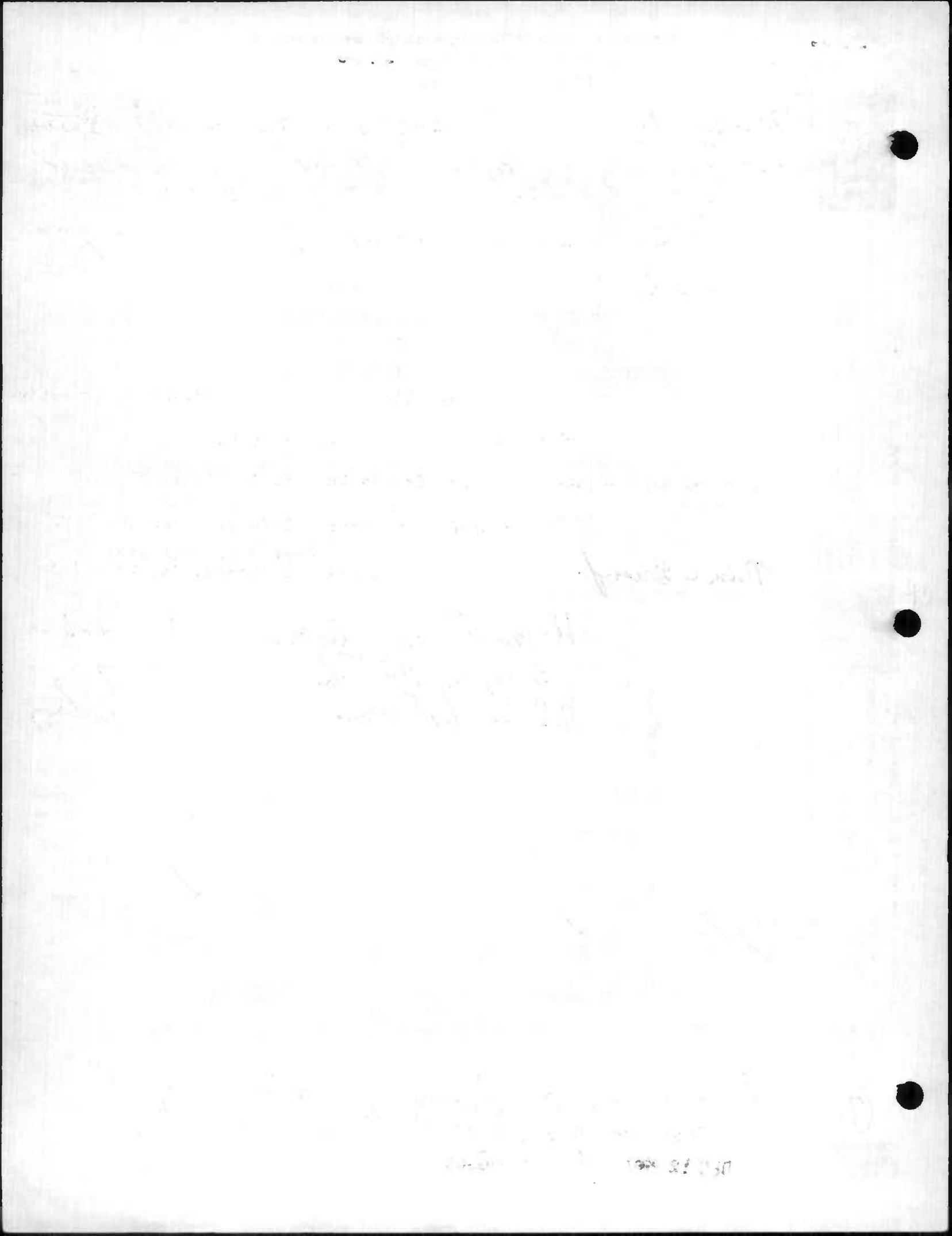
Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

7

State
Registrar



97-7114-037

jhm
ELIZABETH JANE
COPPINS

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38967

| | | | | | | | | |
|--|--|--|---|--|--|---|---|---|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Elizabeth Jane Coppins | | | | 2. Date of Death Month DECEMBER Day 09 , Year 1997 | | 3. Time of Death 15:47 PM | |
| | 4a. Facility Name (If not institution, give street and number) GOLDEN BEACH ROAD | | | | 4b. City, Town, or Location of Death Mechanicsville | | 4c. County of Death ST. MARYS | |
| Funeral Director | 5. Social Security Number 215-38-5040 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 55 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) May 26 1942 | 9. Birthplace (State or Foreign Country) MD |
| | Usual Residence of Decedent | | | | 10a. State MD | | 10b. County St. Mary's | |
| To Be Completed by Funeral Director | 10c. City, Town or Location Mechanicsville | | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number 30052 Hickory Dr. | |
| | 10f. Zip Code 20659 | | | | 10g. Citizen of What Country? U.S.A. | | | |
| | 11. Marital Status <input type="checkbox"/> Navar Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary Secondary (0-12) 12 Collage (1-4or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Auditor | | 16b. Kind of Business/Industry Federal Government | | | |
| | 17. Father's Name (First, Middle, Last) James Theodore Pilkerton | | | | 18. Mother's Name (First, Middle, Maiden Surname) Dorothy Simms Pilkerton | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Lloyd Wayne Coppins/Husband | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 30052 Hickory Dr. Mechanicsville, MD 20659 | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Trinity Mem. Gardens | | 20c. Location - City or Town, State 12/13/97 Waldorf, MD | | 20d. Date | |
| | 21. Signature of Funeral Service Licensee <i>David C. Echols</i> MO0945 | | | | 22. Name and Address of Funeral Home AREHART-ECHOLS FUNERAL HOME, PA P.O. Box 567 LaPlata, MD 20646 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Multiple Injuries Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | | | | |
| 24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | |
| 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) SCENE | | | | | | |
| 27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) 12/9/97 | | 28b. Time of Injury 1544 HR | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) roadway | | 28d. Describe how injury occurred Subject driver, George J. Smith, Jr. + | | | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | |
| 29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| 29b. Signature and title of certifier <i>Theodore M. King</i> | | | | 29c. License number OCME | | 29d. Date signed (Month, Day, Year) DECEMBER 10, 1997 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) THEODORE M. KING 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 15 1997 | | 32. Registrar's Signature <i>John A. Schuler-Randall</i> | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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Physician
/Medical
Examiner

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Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

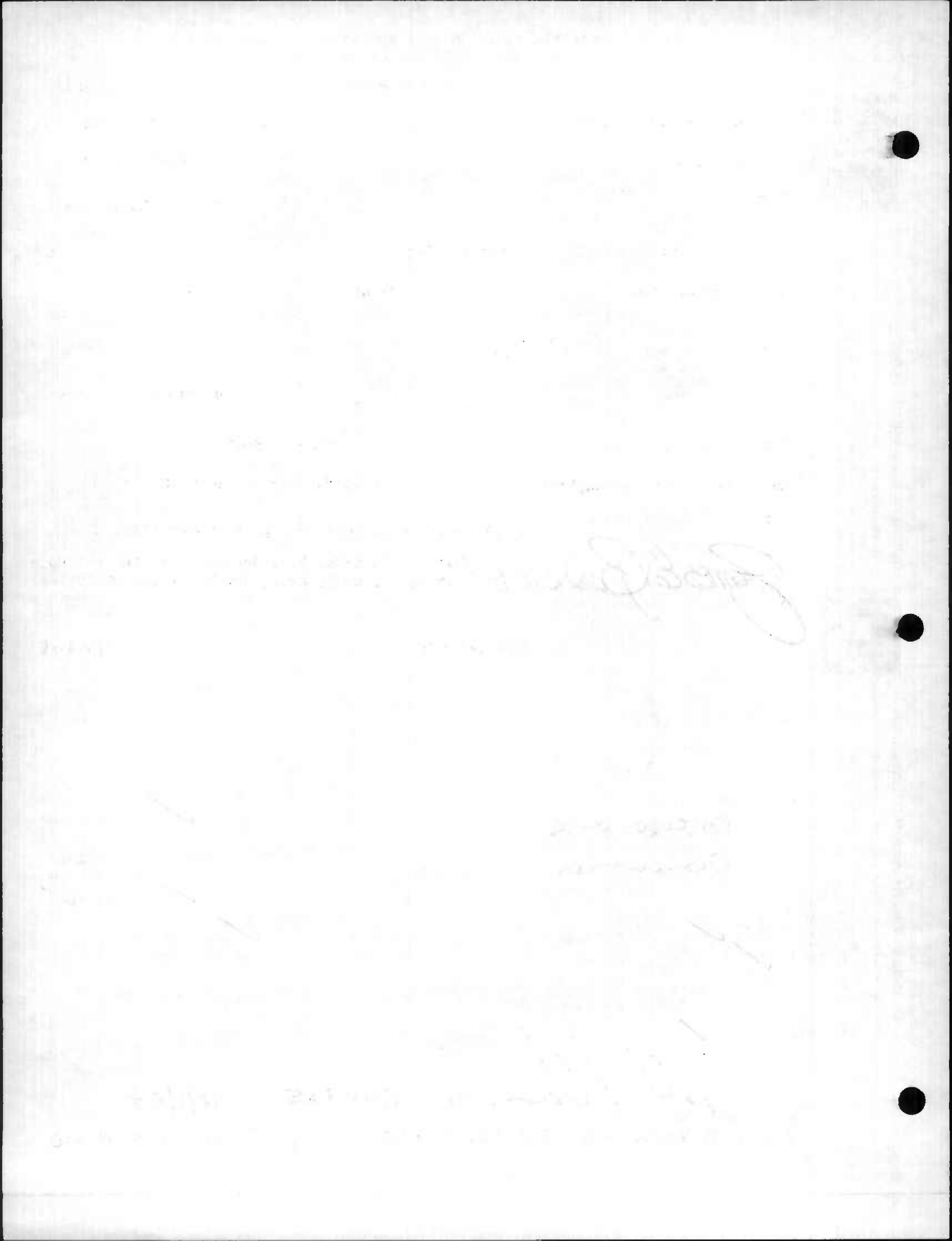
Certificate of Death

Reg. No. 97 38970

| | | | | | | | | |
|--|---|--|---|---|--|--|--|---|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) John Daniel Crowley | | | | 2. Date of Death Month Day Year November 28, 1997 | | 3. Time of Death 10:05 pm | |
| | 4e. Facility Name (If not institution, give street and number) 303 Evergreen Road | | | | 4b. City, Town, or Location of Death Severna Park | | 4c. County of Death Anne Arundel | |
| Funeral Director | 5. Social Security Number 561-54-3758 | 6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 89 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) Sept 24, 1908 | | 9. Birthplace (State or Foreign Country) Massachusetts |
| | Usual Residence of Decedent | | | | | | | |
| To Be Completed by Funeral Director | 10e. State MD | 10b. County Anne Arundel | 10c. City, Town or Location Severna Park | | | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| | 10e. Street and Number 303 Evergreen Road | | | 10f. Zip Code 21146 | | 10g. Citizen of What Country? USA | | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 1931-1961 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4 | | | 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) U.S. Naval Captain | | 16b. Kind of Business/Industry United States Navy | | |
| | 17. Father's Name (First, Middle, Last) John Crowley | | | | 18. Mother's Name (First, Middle, Maiden Surname) Ellen Hurley | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Mary Ellen Crowley/daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 303 Evergreen Road, Severna Park, MD 21146 | | | |
| | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Maryland Veterans Cemetery | | Date Dec 4 1997 | | 20c. Location - City or Town, State Crownsville, MD | |
| | 21. Signature of Funeral Service Licensee <i>James E. Barranco</i> | | | | 22. Name and Address of Facility Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy., Severna Park, MD 21146 | | | |
| | 23a. Part I. Enter the disease, or combination that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. Sepsis Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Osteoporosis Dementia | | | | | | | |
| | 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| | 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. Describe how injury occurred | | | |
| | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| | 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| | 29b. Signature and title of certifier <i>John J. Van, MD</i> | | | | 29c. License number 044225 | | 29d. Date signed (Month, Day, Year) 12/1/97 | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Miles J. Varn, MD 723 Broadwater Way Gibson Island, MD | | | | | | | |
| | 31. Date filed (Month, Day, Year) DEC 04 1997 | | | | 32. Registrar's Signature <i>Julia Davidson-Randall</i> | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



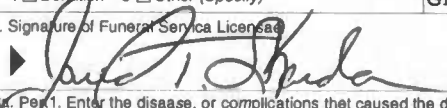
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

38968

| | | | | | | | | | | | |
|---|---|--|---|--|---|--|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) ELIZABETH KOBI CONAWAY | | | | 2. Date of Death Month Day Year NOVEMBER 30 1997 | | 3. Time of Death 10:35 A.M. | | | | |
| | 4a. Facility Name (If not institution, give street and number) HARBOR HOSPITAL CENTER | | | | 4b. City, Town, or Location of Death BALTIMORE | | 4c. County of Death N/A | | | | |
| Funeral Director | 5. Social Security Number 214-46-1025 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 75 Yrs. | | 8. Date of Birth (Month, Day, Year) NOV. 27, 1922 | | | | |
| | 9. Birthplace (State or Foreign Country) SWITZERLAND | | 10a. State MARYLAND | | 10b. County ANNE ARUNDEL | | 10c. City, Town or Location GLEN BURNIE | | | | |
| Usual Residence of Decedent | | | | | | | | | | | |
| 10a. State MARYLAND | | | 10b. County ANNE ARUNDEL | | | 10c. City, Town or Location GLEN BURNIE | | | | | |
| 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | 10e. Street and Number 1224 ASTER DRIVE | | | 10f. Zip Code 21061 | | 10g. Citizen of What Country? U.S.A. | | | |
| 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc. Specify: WHITE | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) N/A | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) AGENT | | | 16b. Kind of Business/Industry REAL ESTATE | | | | | |
| 17. Father's Name (First, Middle, Last) ERNST KOBI | | | | 18. Mother's Name (First, Middle, Maiden Surname) CLAIRE MERTZ | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) ROBERTA MUSCO (DAUGHTER) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 209 WELLHAM AVENUE, GLEN BURNIE, MD. 21061 | | | | | | | |
| 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) GLEN HAVEN MEMORIAL PARK | | | | 20c. Date 12/4/97 | | 20d. Location - City or Town, State GLEN BURNIE, MD. | |
| 21. Signature of Funeral Service Licensee  | | | | 22. Name and Address of Facility SINGLETON FUNERAL HOME, 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061 | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. LIVER FAILURE Due to (or as a consequence of): | | | | | | | | | Approximate Interval Between Onset and Death TWO YEARS | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. HISTORY OF RECTAL CANCER | | | | | | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | | |
| 29b. Signature and title of certifier  Rubina Entesham (HOUSE STAFF) | | | | 29c. License number P. 11938 | | | 29d. Date signed (Month, Day, Year) NOVEMBER 30 1997 | | | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) HARBOR HOSPITAL CENTER 3001 SOUTH HANDOVER STREET, BALTIMORE, MARYLAND 21225 | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 02 1997 | | | 32. Registrar's Signature  | | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38969

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

GEORGE

RAYMOND

CONNELL

2. Date of Death

December 3 1997 9:45 AM

3. Time of Death

Funeral
Director

4a. Facility Name (If not institution, give street and number)

NORTH ARUNDEL Hospital

4b. City, Town, or Location of Death

Glen Burnie

4c. County of Death

Anne Arundel

5. Social Security Number

219-22-0693

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

72 Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

Min.

8. Date of Birth (Month, Day, Year)

MARCH 12, 1925

9. Birthplace (State or Foreign Country)

NEW YORK

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

ANNE ARUNDEL

10c. City, Town or Location

GLEN BURNIE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7801 OAKWOOD ROAD

10f. Zip Code

21061

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No 1942-

If Yes, Give Year or Dates: 1947

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

N/A

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

SHIP YARD WORKER

16b. Kind of Business/Industry

STEEL INDUSTRY

17. Father's Name (First, Middle, Last)

JOSEPH

JAMES

CONNELL

18. Mother's Name (First, Middle, Maiden Surname)

MARIE

CANUFF

19a. Informant's Name/Relationship (Type, Print)

SUELLEN CONNELL (DAUGHTER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7801 OAKWOOD ROAD, GLEN BURNIE, MD. 21061

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

GLEN HAVEN MEMORIAL PARK

Date

12/6/97

20c. Location - City or Town, State

GLEN BURNIE, MD.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

SINGLETON FUNERAL HOME,

1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. ACUTE MYOCARDIAL INFARCTION

Due to (or as a consequence of):

b. CONGESTIVE HEART FAILURE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

Inpatient

2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home5 ☐ Residence8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

A. Zepher

MD

29c. License number

D43977

29d. Date signed (Month, Day, Year)

December 3 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Raymon D. D. 301 Hospital Ave, Glen Burnie, MD. 21061

31. Date filed (Month, Day, Year)

DEC 04 1997

32. Registrar's Signature

Julia Davidson-Randall

State
Registrar

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38971

| | | | | | | | | | | | | | | | | | | | | |
|--|---|---|--|--|---|---|--|---|----|---------------|---|----|--|-------------------|----|--|--------------|----|---|-------------------|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Randy Crowder | | | | 2. Date of Death Month December Day 2 Year 1997 | | 3. Time of Death 6:10 PM | | | | | | | | | | | | | |
| | 4e. Facility Name (If not institution, give street and number) Laurel Regional Hospital | | | | 4b. City, Town, or Location of Death Laurel | | 4c. County of Death Prince Georges | | | | | | | | | | | | | |
| Funeral Director | 5. Social Security Number 579-94-9520 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 36 Yrs. | | 8. Date of Birth (Month, Day, Year) September 25, 1961 | | | | | | | | | | | | | |
| | 9. Birthplace (State or Foreign Country) Washington DC | | 10a. State MD | | 10b. County Prince Georges | | 10c. City, Town or Location Laurel | | | | | | | | | | | | | |
| 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number 8862 Cherry Lane | | 10f. Zip Code 20708 | | 10g. Citizen of What Country? U.S.A. | | | | | | | | | | | | | | |
| 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: Black | | | | | | | | | | | | | | |
| 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Sales Clerk | | 16b. Kind of Business/Industry Parts USA | | | | | | | | | | | | | | | | |
| 17. Father's Name (First, Middle, Last) Leland Crowder | | | | 18. Mother's Name (First, Middle, Maiden Surname) Verlette Thompson | | | | | | | | | | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print) Michelle D. Crowder - Wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8862 Cherry Lane, Laurel MD 20708 | | | | | | | | | | | | | | | | |
| 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Harmony Memorial Park | | Date 12-6-97 | | 20c. Location - City or Town, State Landover, MD | | | | | | | | | | | | | | |
| 21. Signature of Funeral Service Licensee P. Marshall | | | | 22. Name and Address of Facility Marshall's Funeral Home, Inc. 4217 9th Street N.W. Washington DC 20011 | | | | | | | | | | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. | | | | | | | | | | | | | | | | | | | | |
| <table border="0"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last </td> <td>a.</td> <td>SEPSIS</td> <td>Approximate Interval Between Onset and Death 20-25 DAYS</td> </tr> <tr> <td>b.</td> <td>Due to (or as a consequence of): RESPIRATORY FAILURE</td> <td>20-25 DAYS</td> </tr> <tr> <td>c.</td> <td>Due to (or as a consequence of): CHRONIC RENAL FAILURE</td> <td>YEARS</td> </tr> <tr> <td>d.</td> <td>Due to (or as a consequence of): CONGESTIVE HEART FAILURE</td> <td>20-25 DAYS</td> </tr> </table> | | | | | | | | Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | a. | SEPSIS | Approximate Interval Between Onset and Death 20-25 DAYS | b. | Due to (or as a consequence of): RESPIRATORY FAILURE | 20-25 DAYS | c. | Due to (or as a consequence of): CHRONIC RENAL FAILURE | YEARS | d. | Due to (or as a consequence of): CONGESTIVE HEART FAILURE | 20-25 DAYS |
| Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | a. | SEPSIS | Approximate Interval Between Onset and Death 20-25 DAYS | | | | | | | | | | | | | | | | | |
| | b. | Due to (or as a consequence of): RESPIRATORY FAILURE | 20-25 DAYS | | | | | | | | | | | | | | | | | |
| | c. | Due to (or as a consequence of): CHRONIC RENAL FAILURE | YEARS | | | | | | | | | | | | | | | | | |
| | d. | Due to (or as a consequence of): CONGESTIVE HEART FAILURE | 20-25 DAYS | | | | | | | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. INSULIN DEPENDENT DIABETES MELLITUS HYPOTENSION | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | | | | | | | | | | |
| 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | | | | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | |
| 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | | | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | | | | | | | | | | | |
| 29b. Signature and title of certifier James Ansan M.D. | | 29c. License number 36192 | | 29d. Date signed (Month, Day, Year) DECEMBER 3, 1997 | | | | | | | | | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7610 CARROLL AVE. SUITE 380, TAKOMA PARK, MARYLAND 20912 | | | | | | | | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 10 1997 | | 32. Registrar's Signature John Anderson | | | | | | | | | | | | | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

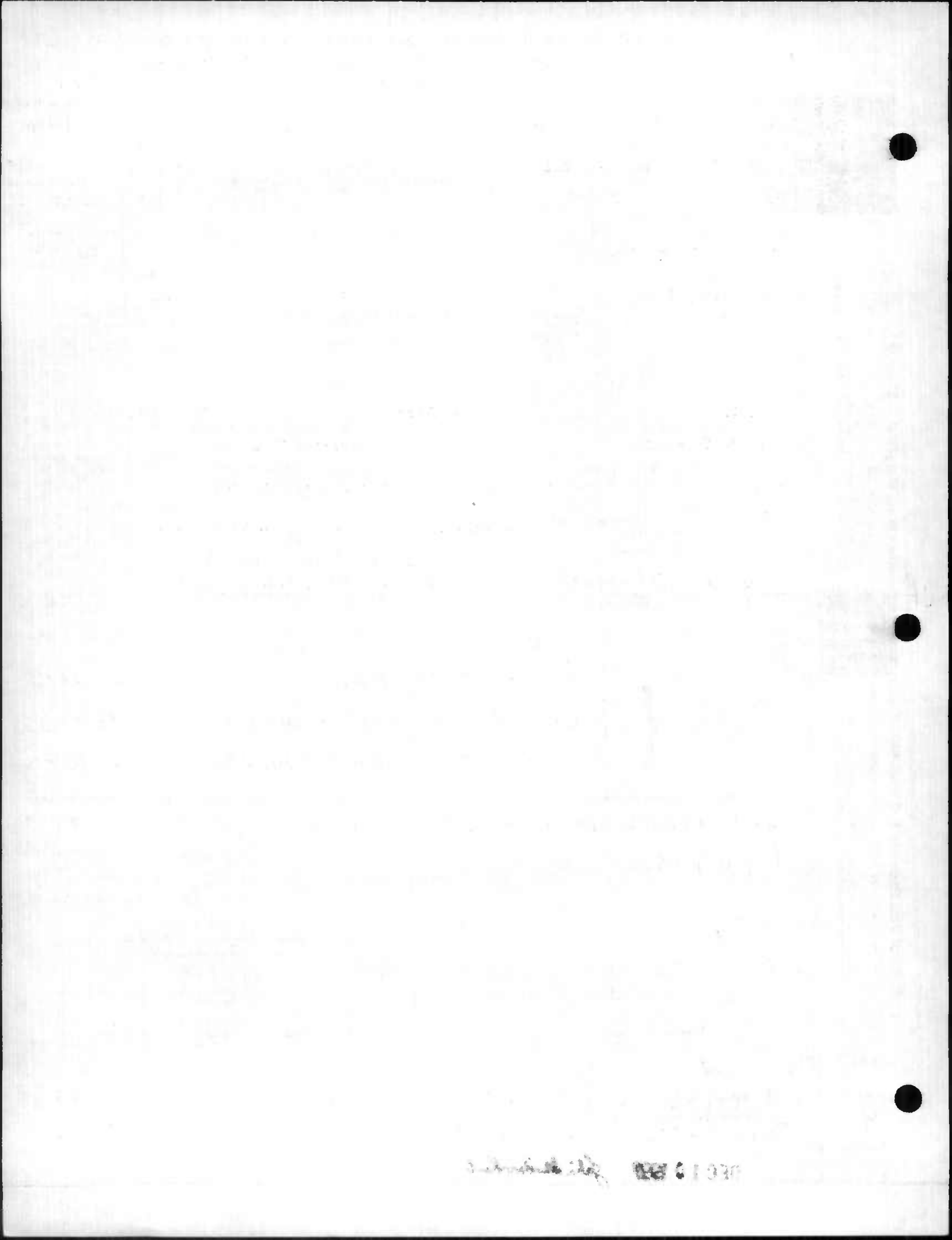
Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

State
Registrar



unk. 97-249
97-6697-033
B.K.S

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

87 38972

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

HELEN LORRAINE COATES

2. Date of Death

Month Day Year
NOV. 20, 1997

3. Time of Death

0235 AM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

PRINCE GEORGES COUNTY HOSPITAL

4b. City, Town, or Location of Death

CHEVERLY

4c. County of Death

PRINCE GEORGES

5. Social Security Number

578-96-9503

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

33

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

May 8, 1964

9. Birthplace (State or Foreign Country)

Washington, D.C.

Usual Residence of Decedent

10a. State

District of Columbia

10b. County

10c. City, Town or Location

Washington

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

5118 Hanna Place, S. E.

10f. Zip Code

20019

10g. Citizen of What Country?

United States

11. Marital Status

1 ☒ Never Married 2 ☐ Married

3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify:
African American

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

10

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Clerk

16b. Kind of Business/Industry

Private

17. Father's Name (First, Middle, Last)

John Coates

18. Mother's Name (First, Middle, Maiden Surname)

Lorraine Cooley

19a. Informant's Name/Relationship (Type, Print)

Ronald Cooley - Brother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

905 Glenwillow Drive, Apt. #3, Seat Pleasant, MD 20743

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Lee's Crematory

Date

10/16/97

20c. Location - City or Town, State

Clinton, MD

21. Signature of Funeral Service Licensee

John T. Stewart III

22. Name and Address of Facility

STEWART FUNERAL HOME, Inc.
4001 Benning Road, N. E., Washington, D. C.

23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cocaine and Narcotic Intoxication
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient

2 ☒ Outpatient

3 ☐ DOA

Other:

4 ☐ Nursing Home

5 ☐ Residence

6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural

2 ☐ Accident

3 ☐ Suicide

4 ☐ Homicide

5 ☐ Pending Investigation

6 ☒ Could not be determined

28a. Date of Injury (Month, Day, Year)

11/00/97

28b. Time of Injury

2:00 AM

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

Subject ingested Drugs.

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Found in house

28f. Location (Street and Number or Rural Route Number, City or Town, State)

315 60th St Washington, DC.

29a. Certifier (Check only one)

1 ☐ Certifying Physician

2 ☒ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Atty & Locally, MD

29c. License number

O.C.M.E

29d. Date signed (Month, Day, Year)

NOV. 20, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Stephen S. Radentz 111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

DEC 09 1997

32. Registrar's Signature

John A. Marshall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

38973

| | | | | | | | | |
|--|---|---|---|--|--|---|---|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) ANTHONY ANDRE CARTER | | | | 2. Date of Death Month Day Year DECEMBER 9, 1997 | | 3. Time of Death 1:39 AM | |
| | 4a. Facility Name (If not institution, give street and number) PHYSICIANS MEMORIAL HOSPITAL A | | | | 4b. City, Town, or Location of Death LAPLATA | | 4c. County of Death CHARLES | |
| Funeral Director | 5. Social Security Number 577-76-3348 | | 6. Sex XXM 2□ F | | 7. Age (In yrs. last birthday) 40 Yrs. | | 8. Date of Birth (Month, Day, Year) SEPT. 18, 1957 | |
| | 9. Birthplace (State or Foreign Country) WASHINGTON, DC | | | | | | | |
| To Be Completed by Funeral Director | Usual Residence of Decedent | | | | | | | |
| | 10a. State N/A | | 10b. County N/A | | 10c. City, Town or Location WASHINGTON, DC | | 10d. Inside City Limits XX Yes 2□ No | |
| | 10e. Street and Number 2627 JASPER ST. SE APT.#3 | | | | 10f. Zip Code 20020 | | 10g. Citizen of What Country? USA | |
| | 11. Marital Status 1□ Never Married 2 XX Married 3□ Widowed 4□ Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1□ Yes 2 XX No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1□ Yes 2 XX No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: BLACK | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Collage (1-4 or 5+) 2 1/2 YRS. | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) LABORER | | 16b. Kind of Business/Industry PVT. | | | |
| | 17. Father's Name (First, Middle, Last) JASON CARTER | | | | 18. Mother's Name (First, Middle, Maiden Surname) ELIZABETH BROWN | | | |
| | 19a. Informant's Name/Relationship (Type, Print) JOANNE CARTER/ WIFE | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2627 JASPER ST. SE #3 WASHINGTON, DC 20020 | | | |
| | 20a. Method of Disposition 1 XX Burial 2□ Cremation 3□ Removal from State 4□ Donation 5□ Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) FT. LINCOLN CEMETERY | | 20c. Date 12-16-97 | | 20d. Location - City or Town, State BRENTWOOD, MD | |
| | 21. Signature of Funeral Service Licensee <i>Joanana D. Blaxton</i> | | | | 22. Name and Address of Facility MARSHALL'S FUNERAL HOME OF MD 4308 SUTTLAND RD. SUTTLAND, MD 20746 | | | |
| | 23a. Pert I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| Physician /Medical Examiner | Immediate Cause (Final disease or condition resulting in death) | | | | Approximate Interval Between Onset and Death 2 wks | | | |
| | a. Pneumonia Due to (or as a consequence of): | | | | | | | |
| | b. AIDS Due to (or as a consequence of): | | | | 6 yrs | | | |
| | c. Due to (or as a consequence of): | | | | | | | |
| | d. Due to (or as a consequence of): | | | | | | | |
| | Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death? 1□ Yes 2□ No 3□ Probably 4 XX Unknown | | | | | | | |
| | 24e. Was an autopsy performed? 1□ Yes 2 XX No | | | | | | | |
| | 24b. Were autopsy findings available prior to completion of cause of death? 1□ Yes 2□ No | | | | | | | |
| 25. Was case referred to medical examiner? 1□ Yes 2 XX No | | 26. Place of Death (Check only one) Hospital: 1 XX Inpatient 2□ ER/Outpatient 3□ DOA Other: 4□ Nursing Home 5□ Residence 6□ Other (Specify) | | | | | | |
| 27. Manner of Death 1 XX Natural 5□ Pending Investigation 2□ Accident 6□ Could not be determined 3□ Suicide 4□ Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1□ Yes 2□ No | | |
| | | 28d. Describe how injury occurred | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one) 1 XX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2□ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier <i>Robert D. ... MD</i> | | 29c. License number D 40479 | | 29d. Date signed (Month, Day, Year) 12/9/97 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 700 OLD LINE CENTER SUITE 100 WALDORF MD. 20602 | | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 12 1997 | | 32. Registrar's Signature <i>John ...</i> | | | | | | |

EXHIBIT 100-111111

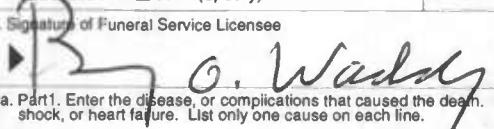
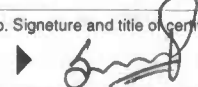

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amended #24a. & 25. Per Doctor P.G.C. 12-11-97c Certificate of Death

Reg. No.

38974

| | | | | | | | | |
|--|--|--|---|--|---|--------------------------------|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) ALEXANDER COLEMAN | | | | 2. Date of Death Month 11 Day 29 Year 1997 | | 3. Time of Death A 11:44M. | |
| | 4a. Facility Name (If not institution, give street and number) HARBOR HOSPITAL CENTER | | | | 4b. City, Town, or Location of Death BALTIMORE, MD | | 4c. County of Death | |
| Funeral Director | 5. Social Security Number 214-26-3671 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 66 Yrs. | If Under 1 Year Months | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) FEB. 13, 1931 | 9. Birthplace (State or Foreign Country) VIRGINIA |
| | Usual Residence of Decedent | | | | | | | |
| To Be Completed by Funeral Director | 10a. State MARYLAND | | 10b. County BALTIMORE | | 10c. City, Town or Location | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| | 10e. Street and Number 2424 MARBOURNE AVE. | | | | 10f. Zip Code 21230 | | 10g. Citizen of What Country? USA | |
| | 11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever In U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: AFROAMERICAN | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) DISABLED | | 16b. Kind of Business/Industry NONE | | | |
| | 17. Father's Name (First, Middle, Last) ROBERT COLEMAN | | | | 18. Mother's Name (First, Middle, Maiden Surname) EDNA RICH | | | |
| Physician /Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) NANCY PINN (sister) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RT. 1, BOX 415 LANCASTER, VA 22503 | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) HOLY TABERNACLE OF GOD | | Date DEC. 3 1997 | | 20c. Location - City or Town, State LANCASTER, VA 22503 | |
| | 21. Signature of Funeral Service Licensee  | | | | 22. Name and Address of Facility BERRY O. WADDY P O. BOX 305 LANCASTER, VA 22503 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. PULMONARY EMBOLISM Due to (or as a consequence of): b. DEEP VENOUS THROMBOSIS OF LT LEG Due to (or as a consequence of): c. OLD CEREBROVASCULAR ACCIDENT Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | | | | Approximate Interval Between Onset and Death 30 mins 12 HRS 10 YEARS |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | | | 28d. Describe how Injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | |
| | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| | 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| State Registrar | 29b. Signature and title of certifier  RESIDENT | | | | 29c. License number A-12441614 | | 29d. Date signed (Month, Day, Year) 11/29/97 | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHARIF CHOWDHURY 3001 S HANOVER ST, BALTIMORE, MD | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 11 1997 | | | | 32. Registrar's Signature  | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND# 2 12-4-97 cms AACO Health Dep't. Certificate of Death

Reg. No.

97 38975

| | | | | | | | | | | |
|--|---|--|---|---|--|--------------------------------|---|---|-----------------------------------|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) Florence M. Deutsch | | | | 2. Date of Death Month 11 Day 23 Year 97 | | 3. Time of Death 0305 | | | |
| | 4a. Facility Name (If not institution, give street and number) Anne Arundel Hospital | | | | 4b. City, Town, or Location of Death Annapolis | | 4c. County of Death AA | | | |
| Funeral Director | 5. Social Security Number 215-82-6456 | | 6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday) 81 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) Nov. 4, 1916 | 9. Birthplace (State or Foreign Country) New York | | |
| | Usual Residence of Decedent | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State MD | | 10b. County Anne Arundel | | 10c. City, Town or Location Severna Park | | | 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | 10e. Street and Number 243 Kennedy Drive | | | | 10f. Zip Code 21146 | | 10g. Citizen of What Country? USA | | | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 | | Collage (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker | | 16b. Kind of Business/Industry Home | | | |
| | 17. Father's Name (First, Middle, Last) Joseph D. O'Reilly | | | | 18. Mother's Name (First, Middle, Maiden Surname) unknown | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Patricia Amantea/granddaughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 996 Belgarden Lane, Pasadena, MD 21122 | | | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Glen Haven Cemetery | | Date Nov 25 1997 | | 20c. Location - City or Town, State Glen Burnie, MD | | | |
| | 21. Signature of Funeral Service Licensee James E. Barranco | | | | 22. Name and Address of Facility Barranco & Sons, P.A. Severna Park Funeral Home 95 Gov. Ritchie Hwy., Severna Park, MD 21146 | | | | | |
| | 23a. Cause of Death (Final disease or condition resulting in death) a. Acute Respiratory Failure Due to (or as a consequence of): b. Large Cell Carcinoma, Lung. Due to (or as a consequence of): c. Due to (or as a consequence of): d. | | | | Approximate Interval Between Onset and Death | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | |
| | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of causa of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| | 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | | | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| | 29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | |
| State Registrar | 29b. Signature and title of certifier William P. Jones, MD Deputy | | | | 29c. License number D06054 | | 29d. Date signed (Month, Day, Year) 11/22/97 | | | |
| | 30. Name and address of person who completed causa of death (Item 23e) (Type, Print) William P. Jones, MD 695 America 21035 | | | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 01 1997 | | 32. Registrar's Signature Julia Davidson-Rendell | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

CD 14. 34-62

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38976

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Edith Naomi Davis

2. Date of Death
Month Day Year

12

06

1997

3. Time of Death
6:00 AM

4a. Facility Name (If not institution, give street and number)

Citizens Nursing Home

4b. City, Town, or Location of Death

Havre de Grace

4c. County of Death

Harford

5. Social Security Number

217-26-1727

6. Sex
1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

100 Yrs.

If Under 1 Year
Months Days

If Under 24 Hrs.
Hours Min.

8. Date of Birth
(Month, Day, Year)

10/15/1897

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Harford

10c. City, Town or Location

Havre de Grace

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

314 Fountain Street

10f. Zip Code

21078

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married

3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Home

17. Father's Name (First, Middle, Last)

Thomas McGonigal

18. Mother's Name (First, Middle, Maiden Surname)

Mae Walker

19a. Informant's Name/Relationship (Type, Print)

Hilda Hutchins- daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

115 Anderson Ave. Havre de Grace, MD 21078

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Angel Hill Cemetery

Date

12/9/97

20c. Location - City or Town, State

Havre de Grace, MD

21. Signature of Funeral Service Licensee

Madelyn Mitchell Shant

22. Name and Address of Facility

Mitchell-Smith Funeral Home, P.A.

123 S. Washington St., Havre de Grace, MD

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. cerebral thromboses

Due to (or as a consequence of):

b. Cardiac Failure

Due to (or as a consequence of):

c. as far as heart disease

Due to (or as a consequence of):

d. Carcinoma not

Approximate Interval Between Onset and Death

4 days

6 months

6 months

1 year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural

2 ☐ Accident

3 ☐ Suicide

4 ☐ Homicide

5 ☐ Pending investigation

6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dr. H. W. Adams

29c. License number

D11491 MD

29d. Date signed (Month, Day, Year)

12/8/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

IRVING L. WACHSMAN

407 S. UNION Ave. Havre de Grace, MD

31. Date filed (Month, Day, Year)

DEC - 9 1997

32. Registrar's Signature

John A. R. R. R.

State Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38977

| | | | | | | | | | |
|--|--|---|---|--|---|--|--|---|---|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) JAMES DYSON | | | | | 2. Date of Death Month Day Year December 5, 1997 | | 3. Time of Death 4:39 P.M. | |
| | 4a. Facility Name (If not institution, give street and number) PRINCE GEORGES HOSPITAL CENTER | | | | | 4b. City, Town, or Location of Death Cheverly | | 4c. County of Death Prince George's | |
| Funeral Director | 5. Social Security Number 577-26-3468 | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday) 77 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Year) Mar. 13, 1920 | | 9. Birthplace (State or Foreign Country) Washington, D.C. | |
| | Usual Residence of Decedent | | | | | | | | |
| To Be Completed by Funeral Director | 10e. State District of Columbia | | 10b. County Washington | | 10c. City, Town or Location Washington | | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | 10e. Street and Number 301 40th Street, N. E. | | | | 10f. Zip Code 20019 | | 10g. Citizen of What Country? United States | | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: African American | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Business Agent - Teamsters | | 16b. Kind of Business/Industry Private - Local 639 | | | | |
| | 17. Father's Name (First, Middle, Last) William Dyson | | | | | 18. Mother's Name (First, Middle, Maiden Surname) Katherine Briscoe | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) Ruth Berry Dyson - Wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 301 40th Street, N.E., Washington, D.C. 20019 | | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Olivet Cemetery | | Date 12/13/97 | | 20c. Location - City or Town, State Washington, D. C. | | |
| | 21. Signature of Funeral Service Licensee <i>John T. Stewart III</i> | | | | 22. Name and Address of Facility STEWART FUNERAL HOME, Inc. 4001 Benning Road, N.E., Washington, D.C. | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | Approximate Interval Between Onset and Death |
| | Immediate Cause (Final disease or condition resulting in death) a. Cardiac failure Due to (or as a consequence of): b. Cardio myopathy Due to (or as a consequence of): c. Renal failure Due to (or as a consequence of): d. | | | | | | | | 3 days Signs 1 month |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| | | | | | | | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| 29b. Signature and title of certifier <i>Sudhakar Punja</i> | | | | 29c. License number D 2 00 72 | | 29d. Date signed (Month, Day, Year) 12/8/97 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sudhakar Punja, M.D., 7219 Hanover Parkway, Greenbelt, Maryland 20770 | | | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 11 1997 | | 32. Registrar's Signature <i>[Signature]</i> | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

6

[Faint, mostly illegible text at the top of the page, possibly a header or introductory paragraph.]

[Handwritten text in the middle section, appearing to be a list or series of notes.]

[Faint, mostly illegible text at the bottom of the page, possibly a conclusion or footer.]

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38978

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

MARY A. DAVIS

2. Date of Death

Month Day Year
Dec 7 1997

3. Time of Death

8:24 AM

4a. Facility Name (If not institution, give street and number)

PRINCE GEORGES HOSPITAL CENTER

4b. City, Town, or Location of Death

CHEVERLY

4c. County of Death

PRINCE GEORGE

Funeral
Director

5. Social Security Number

216-12-4570

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

Yrs. 79

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

8/2/18

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State
Md.

10b. County
P.G.

10c. City, Town or Location
Capitol Hgts.

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1210 Carrington Ave.

10f. Zip Code

20743

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8th

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Andrew Queen

18. Mother's Name (First, Middle, Maiden Surname)

Nellie M. Hawkins

19a. Informant's Name/Relationship (Type, Print)

Phoenix A. Davis/Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Same as # 10 above

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

12/12/97
Maryland Nat'l. Mem. Park

Date

20c. Location - City or Town, State

Laurel, Md.

21. Signature of Funeral Service Licensee

Darryl W. Bratt

22. Name and Address of Facility

H.S. Washington & Sons Co., Inc.
4925 Burroughs Ave., N.E.

23a. Pert I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. *Left Breast Carcinoma.*

Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

left Pleural effusion

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home

5 ☐ Residence

8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury et Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

N. Ashai M.D.

29c. License number

D48213

29d. Date signed (Month, Day, Year)

12-8-97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N. Ashai 4000 Mitchellville Road #220 Bowie MD 20716

State
Registrar

31. Date filed (Month, Day, Year)

DEC 11 1997

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

AMENDED #8 12/15/97 PGHD ELM

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

Carlene - Davis

2. Date of Death

Month 12 Day 8 Year 97

3. Time of Death

6:50pm

4a. Facility Name (If not institution, give street and number)

Manor Care-Largo

4b. City, Town, or Location of Death

Largo

4c. County of Death

P.G.

5. Social Security Number

578-24-8462

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

92 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
10-12-05

9. Birthplace (State or Foreign Country)

Charles City

Usual Residence of Decedent

10a. State

MD

10b. County

PRINCE GEORGES

10c. City, Town or Location

LANDOVER

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

8129 Landover Rd.

10f. Zip Code

20785

10g. Citizen of What Country?

UNITED STATES

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: Black

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

12th Grade

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Government Employee

16b. Kind of Business/Industry

Unavailable

17. Father's Name (First, Middle, Last)

Samuel Jones

18. Mother's Name (First, Middle, Maiden Surname)

Emma Brown

19a. Informant's Name/Relationship (Type, Print)

Margaret Kenner

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8129 Landover Rd. Landover, MD 20785

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Arlington National

Date

12/16

20c. Location - City or Town, State

Arlington, Va

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

E.M.DUDLEY FUNERAL HOME

3200 Rhode Island Ave. Mt. Rainier, MD 207

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Atherosclerotic Heart Disease months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death 12

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how Injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D20108

29d. Date signed (Month, Day, Year)

12/10/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Rakesh Arora, MD 14300 Gallant Fox Lane Suite 222 Bowie MD 20715

31. Date filed (Month, Day, Year)

DEC 10 1997

32. Registrar's Signature

State Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

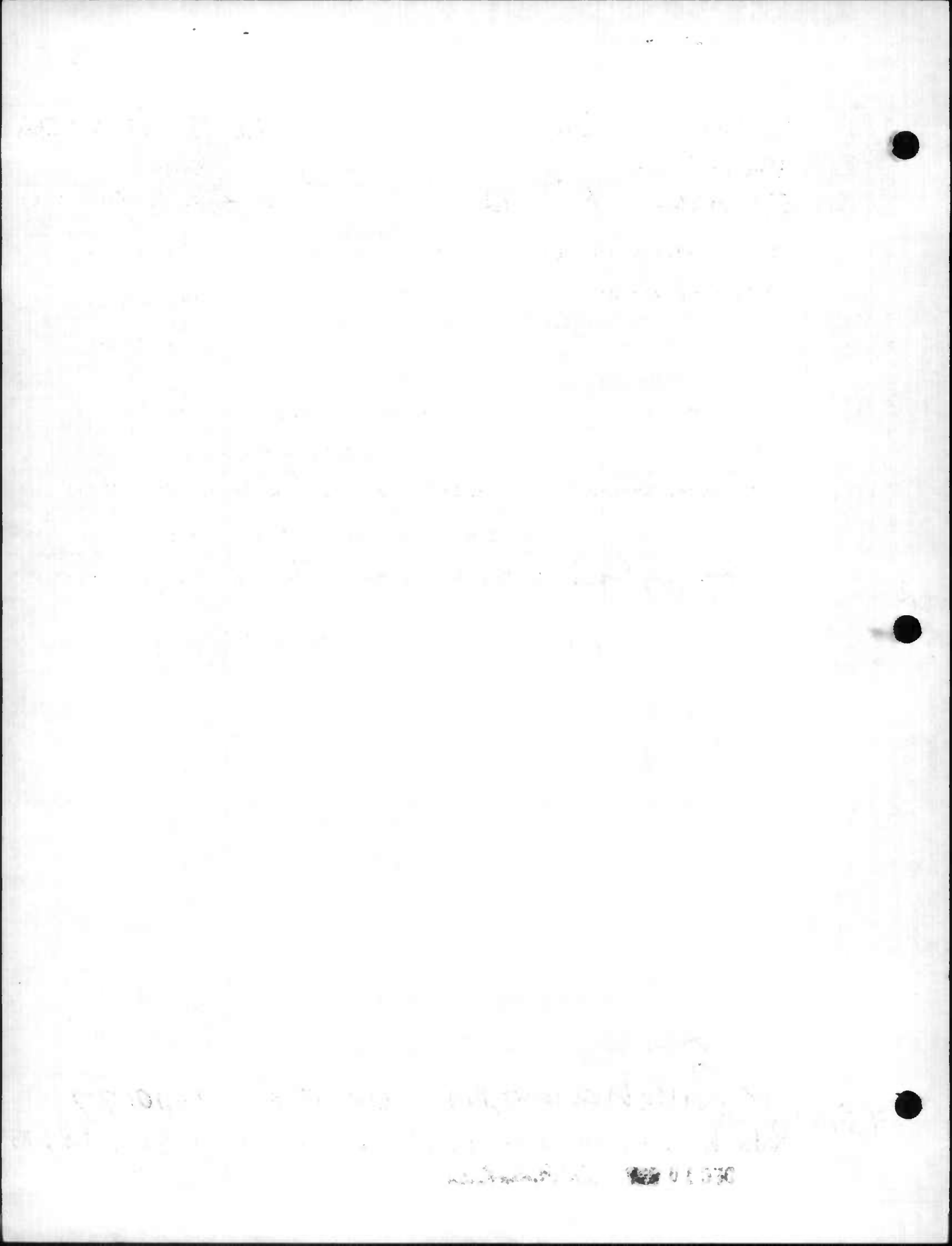
Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 38980

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Shirley D James

2. Date of Death

Month Day Year
Dec 6 1997

3. Time of Death

11:46 am

4a. Facility Name (If not institution, give street and number)

Holy Cross Hospital

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

241-52-6560

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

62 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
April 1, 1935

9. Birthplace (State or Foreign Country)

North Carolina

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Wheaton

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

12921 Bluet Lane

10f. Zip Code

20906

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No -
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: Black

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12th

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Accountant

16b. Kind of Business/Industry

Dept. of Army

17. Father's Name (First, Middle, Last)

Albert J. Davis

18. Mother's Name (First, Middle, Maiden Surname)

Blannie Pierce

19a. Informant's Name/Relationship (Type, Print)

Samuel James - Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12921 Bluet Lane Wheaton, MD 20906

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Pleasant Plains Bapt.Ch. 12-11

Date

12-11

20c. Location - City or Town, State

Ahoskie, N.C.

21. Signature of Funeral Service Licensee

J. P. Marshall

22. Name and Address of Facility

Marshall's Funeral Home, Inc.

4217 9th Street N W Washington DC 20011

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

e. Congestive Heart Failure

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

2 weeks

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Coronary artery disease
Diabetes mellitus

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?
1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

John A. Leach

29c. License number

208546

29d. Date signed (Month, Day, Year)

Dec - 6 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

John A. Leach 8218 Wisconsin Ave Bethesda Md

31. Date filed (Month, Day, Year)

DEC 10 1997

32. Registrar's Signature

John A. Leach

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be dated for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

10

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38981

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

LEON AUSTIN DIGGS

2. Date of Death

Month
12Day
06Year
97

3. Time of Death

6:08 pm

4a. Facility Name (If not institution, give street and number)

Prince George County Hospital

4b. City, Town, or Location of Death

Cheverly MD

4c. County of Death

PG

5. Social Security Number

578-20-6895

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

75

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

Month, Day, Year

9-1-22

9. Birthplace (State or Foreign Country)

DC

Usual Residence of Decedent

10a. State

MD

10b. County

PG

10c. City, Town or Location

Ft Washington

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

7613 Jaywick Avenue

10f. Zip Code

20744

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12th

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Construction Worker

16b. Kind of Business/Industry

Private

17. Father's Name (First, Middle, Last)

Cornelius R. Diggs

18. Mother's Name (First, Middle, Maiden Surname)

Irene Alice Joyce

19a. Informant's Name/Relationship (Type, Print)

Sandra Lomax/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7613 Jaywick Avenue, Ft Wash MD 20744

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Forest Hill Cemetery

Date

12/13/97

20c. Location - City or Town, State

Clinton MD

21. Signature of Funeral Service Licensee

Robert G. Mason

22. Name and Address of Facility

Robert G. Mason Funeral Home

1661 Good Hope Rd SE Wash DC 20020

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

Due to (or as a consequence of):

PNEUMONIA

Approximate Interval Between Onset and Death

5 DAYS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

RENAL FAILURE

HYPERTENSION

CEREBROVASCULAR THROMBOSIS

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

28. Place of Death (Check only one)

4 ☐ Nursing Home5 ☐ Residence8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dennis Hand

29c. License number

D04988

29d. Date signed (Month, Day, Year)

12/17/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DENNIS HAND MD 4203 QUEENSBURY RD HYATTSVILLE MD 20781

31. Date filed (Month, Day, Year)

DEC 10 1997

32. Registrar Signature

John Dwyer

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 38982

Certificate of Death

Reg. No.

| | | | | | | | | | | | |
|--|--|--|---|---|--|--------------------------|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedant's Name (First, Middle, Last) Virginia Celeste Edgell | | | | 2. Date of Death Month Day Year November 28, 1997 | | | | 3. Time of Death 1:20 am | | |
| | 4a. Facility Name (If not Institution, give street and number) Anne Arundel Medical Center | | | | 4b. City, Town, or Location of Death Annapolis | | | | 4c. County of Death Anne Arundel | | |
| Funeral Director | 5. Social Security Number 222-07-4772 | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) 86 Yrs. | | 8. Date of Birth (Month, Day, Year) July 30, 1911 | | 9. Birthplace (State or Foreign Country) Delaware | | |
| | Usual Residence of Decedant | | | | 10c. City, Town or Location Seaford | | 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | |
| To Be Completed by Funeral Director | 10e. State DE | | 10b. County Sussex | | 10f. Zip Code 19973 | | 10g. Citizen of What Country? USA | | | | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Collega (1-4 or 5+) 4 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) School Teacher | | 16b. Kind of Business/Industry Public Education | | | | | | |
| | 17. Father's Name (First, Middle, Last) Norman Rawlins | | | | 18. Mother's Name (First, Middle, Maiden Surname) Frances Purvis | | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Neil G. Edgell, Sr. | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 121 Greenbrier Lane, Seaford, DE 19973 | | | | | | |
| | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) St. Johnstown Cemetery | | 20c. Location - City or Town, State Greenwood, DE | | | | | | |
| | 21. Signature of Funeral Service Licensee James E. Berson | | | | 22. Name and Address of Facility Barranco & Sons, P.A. Severna Park 495 Gov. Ritchie Hwy., Severna Park, MD 21146 | | | | | | |
| | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Pulmonary Edema Due to (or as a consequence of): CONGESTIVE HEART FAILURE Due to (or as a consequence of): ISCHEMIC CARDIOMYOPATHY Approximate Interval Between Onset and Death 72 hours 5 years 5 years | | | | | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CHRONIC LYMPHOCYtic LEUKEMIA | | | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | |
| | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. Signature and title of certifier Michael R. Freedman, MD | | | | 29c. License number D0052245 | | 29d. Date signed (Month, Day, Year) November 28, 1997 | |
| 30. Name and address of person who completed causa of death (Item 23a) (Type, Print) MICHAEL R. FREEDMAN, MD 205 Ridgely Ave Annapolis, MD 21401 | | | | 31. Data filed (Month, Day, Year) DEC 04 1997 | | | | 32. Registrar's Signature Julia Davidson-Randall | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 38983

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|--|---|--|---|--------------------------------------|--|--|---|-------------------|--|--------------------------------|---|---------------|---|--|--|----|-------------------------|---------------|----------------------------------|--|--|--|----|-------------------------------|------------------|----------------------------------|--|--|----|--|--|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) WILBUR ALLEN FAULKNER | | | | 2. Date of Death Month December Day 08 Year 1997 | | 3. Time of Death 1:27 pm | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 4a. Facility Name (If not institution, give street and number) Dorchester General Hospital | | | | 4b. City, Town, or Location of Death Cambridge | | 4c. County of Death Dorchester | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Funeral Director | 5. Social Security Number 219-28-2758 | | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 65 Yrs. | | 8. Date of Birth (Month, Day, Year) July 30, 1932 | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 9. Birthplace (State or Foreign Country) Maryland | | 10a. State Maryland | | 10b. County Dorchester | | 10c. City, Town or Location Cambridge | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| To Be Completed by Funeral Director | 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number 701 Locust Street | | 10f. Zip Code 21613 | | 10g. Citizen of What Country? US | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever In U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Maintenance Worker | | 16b. Kind of Business/Industry Rehabilitation Center | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 17. Father's Name (First, Middle, Last) Wilbur W. Faulkner | | | | 18. Mother's Name (First, Middle, Maiden Surname) Pearl Marie Paul | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Jesse W. Faulkner Brother | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 409 Robbins Street Cambridge, Maryland 21613 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Cambridge Cemetery | | 20c. Location - City or Town, State 12/11/97 Cambridge, Maryland | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility Thomas Funeral Home, P.A. 700 Locust Street Cambridge, Maryland 21613 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | <table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a.</td> <td>Ventricular Fibrillation</td> <td>1 Hour</td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>b.</td> <td>Cardiac Ischemia</td> <td>3 Days</td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td rowspan="4">Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last</td> <td>c.</td> <td>Coronary Heart Disease</td> <td>Sev Years</td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>d.</td> <td></td> <td></td> </tr> <tr> <td colspan="2"></td> <td></td> </tr> </table> | | | | | | | | Immediate Cause (Final disease or condition resulting in death) | a. | Ventricular Fibrillation | 1 Hour | Due to (or as a consequence of): | | | b. | Cardiac Ischemia | 3 Days | Due to (or as a consequence of): | | | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | c. | Coronary Heart Disease | Sev Years | Due to (or as a consequence of): | | | d. | | | | | |
| | Immediate Cause (Final disease or condition resulting in death) | a. | Ventricular Fibrillation | 1 Hour | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Due to (or as a consequence of): | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| b. | | Cardiac Ischemia | 3 Days | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Due to (or as a consequence of): | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | c. | Coronary Heart Disease | Sev Years | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | Due to (or as a consequence of): | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | d. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <table border="1"> <tr> <td>Alcoholism</td> <td>23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown</td> </tr> <tr> <td>Alcoholic Liver Disease</td> <td>24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</td> </tr> <tr> <td></td> <td>24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> </table> | | | | | | | | Alcoholism | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | Alcoholic Liver Disease | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | | |
| Alcoholism | 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Alcoholic Liver Disease | 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury M | | 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28d. Describe how injury occurred | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 29b. Signature and title of certifier | | | | 29c. License number 246111 | | 29d. Date signed (Month, Day, Year) 12/10/97 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) William C. Todd Jr P.O. Box 439 Cambridge, Maryland 21613 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 11 1997 | | 32. Registrar's Signature | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND# 14 cms 12-22-97 AACO Health Dept. Certificate of Death

Reg. No. 97 38984

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last) **WALTER E. GRAY** 2. Date of Death Month **NOV.** Day **29** Year **1997** 3. Time of Death **8:30 am**

Funeral
Director

4a. Facility Name (If not Institution, give street and number) **1802 D COPELAND STREET** 4b. City, Town, or Location of Death **ANNAPOLIS** 4c. County of Death **ANNE ARUNDEL**

5. Social Security Number **216-44-9601** 6. Sex ☒ M ☐ F 7. Age (In yrs. last birthday) **77** Yrs. 8. Date of Birth (Month, Day, Year) **SEPT. 17 1920** 9. Birthplace (State or Foreign Country) **MARYLAND**

10a. State **MARYLAND** 10b. County **ANNE ARUNDEL** 10c. City, Town or Location **ANNAPOLIS** 10d. Inside City Limits ☒ Yes ☐ No

10e. Street and Number **1802 D COPELAND STREET** 10f. Zip Code **21401** 10g. Citizen of What Country? **US**

11. Marital Status ☐ Never Married ☐ Married ☒ Widowed ☐ Divorced 12. Was Decedent Ever in U.S. Armed Forces? ☒ Yes ☐ No If Yes, Give Year or Dates: **W.W. II** 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ☐ Yes ☒ No Specify: 14. Race - American Indian, Black, White, etc. Specify: **BLACK American Indian**

15. Decedent's Education (Specify only highest grade completed) **11th** 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) **SUPPLY ENGINEER** 16b. Kind of Business/Industry **FEDERAL GOVERNMENT**

17. Father's Name (First, Middle, Last) **WALTER L. GRAY** 18. Mother's Name (First, Middle, Maiden Surname) **ELIZABETH M. PROCTOR**

19a. Informant's Name/Relationship (Type, Print) **STEPHANIE ARIZMENDI (DAUGHTER)** 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) **8163 NEW CUT ROAD SEVERN, MARYLAND 21144**

20a. Method of Disposition ☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) **ANNAPOLIS MEM. GARDENS** Date **12/4/97** 20c. Location - City or Town, State **ANNAPOLIS, MD.**

21. Signature of Funeral Service Licensee **Harry D. Reese** 22. Name and Address of Facility **WM. REESE & SONS MORTUARY, P.A. 821 WEST ST. ANNAPOLIS, MD. 21401**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death) **CANCER RECTUM** Due to (or as a consequence of): **4 YRS**
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
Due to (or as a consequence of):
Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? ☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed? ☐ Yes ☒ No 24b. Were autopsy findings available prior to completion of cause of death? ☐ Yes ☐ No

25. Was case referred to medical examiner? ☐ Yes ☒ No 26. Place of Death (Check only one) Hospital: ☐ Inpatient ☐ ER/Outpatient ☐ DOA Other: ☐ Nursing Home ☒ Residence ☐ Other (Specify)

27. Manner of Death ☒ Natural ☐ Accident ☐ Suicide ☐ Homicide ☐ Pending investigation ☐ Could not be determined 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury **M** 28c. Injury at Work? ☐ Yes ☒ No 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier **Dr. Watkins** 29c. License number **DO 8118** 29d. Date signed (Month, Day, Year) **12/2/97**

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) **DR. Watkins 900 Bestgate Rd. Annapolis, Md 21401**

31. Date filed (Month, Day, Year) **DEC 05 1997** 32. Registrar's Signature **Julia Davidson-Randall**

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Page 1 of 1

CONFIDENTIAL - SECURITY INFORMATION

CONFIDENTIAL - SECURITY INFORMATION

CONFIDENTIAL - SECURITY INFORMATION

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38985

Physician
/Medical
Examiner

Funeral
Director

1. Decedent's Name (First, Middle, Last)

Edward Augustus Griffith

2. Date of Death

Month

Day

Year

12

07

97

3. Time of Death

2:45 AM

4a. Facility Name (If not institution, give street and number)

Suburban Hospital

4b. City, Town, or Location of Death

Bethesda

4c. County of Death

Montgomery

5. Social Security Number

N/A

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

84

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

08-09-13

9. Birthplace (State or Foreign Country)

Guyana

South America

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Rockville

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

13306 Midway Avenue

10f. Zip Code

20851

10g. Citizen of What Country?

Guyana, South America

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Conductor

16b. Kind of Business/Industry

Government

17. Father's Name (First, Middle, Last)

Thomas Griffith

18. Mother's Name (First, Middle, Maiden Surname)

Ager Morrison

19a. Informant's Name/Relationship (Type, Print)

Vermine Williams/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

13306 Midway Avenue, Rockville, MD 20851

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

George Washington Cem

Date

12/13

97

20c. Location - City or Town, State

Adelphi, Maryland

21. Signature of Funeral Service Licensee

Nancy A. Perantie

22. Name and Address of Facility

J. B. Jenkins Funeral Home

7474 Landover Road, Landover, Maryland 20785

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Metastatic Liver Carcinoma

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Insulin Dependent Diabetes Mellitus

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

William J. Nivala

29c. License number

D45285

29d. Date signed (Month, Day, Year)

December 10, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

18111 Prince Phillip Dr., suite 212, Olney, Md.

31. Date filed (Month, Day, Year)

DEC 11 1997

32. Registrar's Signature

John H. Randall

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23e-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Edward Griffith, Jr. Dec 7, 1997 2:45 PM

(3)

Trans A 1941

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38986

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

AMELIA JACKSON GRESHAM

2. Date of Death

December 6, 1997

3. Time of Death

11:45PM

4a. Facility Name (If not institution, give street and number)

DOCTORS HOSPITAL

4b. City, Town, or Location of Death

LANHAM

4c. County of Death

P.G. COUNTY

Funeral
Director

5. Social Security Number

214-24-2496

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

76

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

AUGUST 18, 1921

9. Birthplace (State or Foreign Country)

BALTIMORE MD

Usual Residence of Decedent

10a. State

MD

10b. County

P.G. COUNTY

10c. City, Town or Location

GLENN DALE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

5200 JANESDALE CT.

10f. Zip Code

20769

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: BLACK

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

Collage (1-4or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

HAIR DRESSER

16b. Kind of Business/Industry

PRIVATE

17. Father's Name (First, Middle, Last)

EDWARD JACKSON

18. Mother's Name (First, Middle, Maiden Surname)

MARY JOHNS

19a. Informant's Name/Relationship (Type, Print)

KEVIN GRESHAM SR./son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5200 JANESDALE CT GLENN DALE MD 20769

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

MT. CALVARY CEMETERY

Date

12-11-97

20c. Location - City or Town, State

GLEN BURNIE MD

21. Signature of Funeral Service Licensee

Aly S Pope Jr

22. Name and Address of Facility

ALEXANDER S. POPE FUNERAL HOMES
5538 MARLBORO PIKE FORESTVILLE MD 2074323a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a.

Hypertension

Due to (or as a consequence of):

b.

Myocardial Failure

Due to (or as a consequence of):

c.

Atherosclerotic Coronary Vascular Disease

Due to (or as a consequence of):

d.

Approximate
Interval Between
Onset and Death

1 Day

3 Days

2 years

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Ischemic Heart Failure

Bicuspid Aortic Valve Right Iliac Artery
Surgery For Repair of Bicuspid Aortic Valve after open heart bypass

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending

Investigation

6 ☐ Could not be

determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of

Injury

M

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician2 ☐ Medical ExaminerTo the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Aly S Pope Jr

29c. License number

D23586

29d. Date signed (Month, Day, Year)

12/8/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Brian S Bayly, MD 7223 Newover Pkwy Greenbelt Md 20770

31. Date filed (Month, Day, Year)

DEC 11 1997

32. Registrar's Signature

Aly S Pope Jr

State
RegistrarGRESHAM, Amelia
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38987

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Theodore Lindberg Gates

2. Date of Death

Month Day Year
December 6, 1997

3. Time of Death

7:55 P.M.

4a. Facility Name (If not institution, give street and number)

11009 Gates Drive

4b. City, Town, or Location of Death

Fort Washington

4c. County of Death

Prince George's

Funeral
Director

5. Social Security Number

578-32-4643

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

70

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Feb. 1, 1927

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Fort Washington

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

11009 Gates Drive

10f. Zip Code

20744

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☐ No

If Yes, Give Year or Dates: 1944-46

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

11

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Self Employed - Proprietor

16b. Kind of Business/Industry

Lindy's Marine Center

17. Father's Name (First, Middle, Last)

Theodore Phillip Gates

18. Mother's Name (First, Middle, Maiden Surname)

Annie Laurie Raum

19a. Informant's Name/Relationship (Type, Print)

Joan M. Gates/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11009 Gates Dr. Ft. Washington, Md. 20744

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Cedar Hill Cemetery 12/10/97

Date

20c. Location - City or Town, State

Suitland, Maryland

21. Signature of Funeral Service Licensee

George P. Kalas

22. Name and Address of Facility

George P. Kalas Funeral Home
6160 Oxon Hill Rd. Oxon Hill, Md. 20745

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. HEAD & NECK CANCER
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

13 MONTHS

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Day Sharma MD

29c. License number

D41119

29d. Date signed (Month, Day, Year)

December 8, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DAYA SHARMA 50 W EDMONSTON DR #303

Rockville MD 20852

31. Date filed (Month, Day, Year)

DEC 08 1997

32. Registrar's Signature

John Anderson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

87 38988

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Shirley Kelly Grady

2. Date of Death

Month Day Year
December 6, 1997

3. Time of Death

3:30 pm

4a. Facility Name (If not institution, give street and number)

22 Ridge Road #223

4b. City, Town, or Location of Death

Greenbelt

4c. County of Death

Prince George's

Funeral
Director

5. Social Security Number

218-24-3080

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

69 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Nov. 4, 1928

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Greenbelt

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

22 Ridge Road #223

10f. Zip Code

20770

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12) College (1-4 or 5+)
12

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Customer Service

16b. Kind of Business/Industry

Book Distribution Co.

17. Father's Name (First, Middle, Last)

William Kelly

18. Mother's Name (First, Middle, Maiden Surname)

Dorothy Liedlich

19a. Informant's Name/Relationship (Type, Print)

Maureen K. Davis - Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10504 Woodleigh Court, Beltsville, Maryland 20705

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metropolitan Crematory 12/10/97 Alexandria, Virginia

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

► Claudette J. Gasch

22. Name and Address of Facility

Francis Gasch's Sons Funeral Home, P.A.
4739 Baltimore Avenue, Hyattsville, MD 20781

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Metastatic Breast Cancer

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

8 Months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

► Clara Chan M.D.

29c. License number

D41828

29d. Date signed (Month, Day, Year)

December 8, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Clara Chan, M.D. 7525 Greenway Center Drive #205, Greenbelt, MD 20770-3532

31. Date filed (Month, Day, Year)

DEC 08 1997

32. Registrar's Signature

John A. Anderson

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38989

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

John Marion Holly

2. Date of Death

October 7, 1997

3. Time of Death

9:20 AM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

21975 Baja Lane

4b. City, Town, or Location of Death

Great Mills

4c. County of Death

St. Mary's

5. Social Security Number

578-38-2366

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

74 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

December 14, 1922 Maryland

9. Birthplace (State or Foreign Country)

Usual Residence of Decedent

10a. State

Maryland

10b. County

St. Mary's

10c. City, Town or Location

Great Mills

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

21975 Baja Lane

10f. Zip Code

20634

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: Black

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

11

College (1-4or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Custodian

16b. Kind of Business/Industry

State Hospital

17. Father's Name (First, Middle, Last)

James Matthew Holly

18. Mother's Name (First, Middle, Maiden Surname)

Rose Helen Young

19a. Informant's Name/Relationship (Type, Print)

Mary C Hebb, Sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

21975 Baja Lane, Great Mills, Maryland 20634

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

MD Veteran's Cemetery

Date

10/14/97

20c. Location - City or Town, State

Cheltenham, Maryland

21. Signature of Funeral Service Licensee

Edward N. Brinsfield, Jr.

22. Name and Address of Facility

Brinsfield Funeral Home, P.A.

22955 Hollywood Road, Leonardtown, MD 20650

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Peptic Ulcer Disease

Due to (or as a consequence of):

6 months

b. Anemia

Due to (or as a consequence of):

6 months

c. Mild Congestive Heart Failure

Due to (or as a consequence of):

2 years

d. Poor PO Intake & Weight Loss

4 months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

R. Jhaveri -

29c. License number

D 32651

29d. Date signed (Month, Day, Year)

10/9/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Rita B Jhaveri, M.D. 22335 Exploration Drive, Lexington Park, MD 20653

State
Registrar

31. Date filed (Month, Day, Year)

DEC 19 1997

32. Registrar's Signature

John Davidson Randall

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38990

| | | | | | | | | | | | | | | | | | | | | | |
|--|--|---|---|--|---|--|--|--|---|----|--------------------|--|----|---|---------|----|--|-------|----|----------------------------------|---------|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) William Frew Henry | | | | 2. Date of Death Month Day Year December 1 1997 | | 3. Time of Death 8:10 AM | | | | | | | | | | | | | | |
| | 4a. Facility Name (If not Institution, give street and number) Anne Arundel Medical Center | | | | 4b. City, Town, or Location of Death Annapolis | | 4c. County of Death Anne Arundel | | | | | | | | | | | | | | |
| Funeral Director | 5. Social Security Number 265-44-2280 | | 6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday) 65 Yrs. | | 8. Date of Birth (Month, Day, Year) Aug 12, 1932 | | | | | | | | | | | | | | |
| | 9. Birthplace (State or Foreign Country) New York | | 10a. State MD | | 10b. County Anne Arundel | | 10c. City, Town or Location Arnold | | | | | | | | | | | | | | |
| To Be Completed by Funeral Director | 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 10e. Street and Number 1235 Timberturn | | 10f. Zip Code 21012 | | 10g. Citizen of What Country? USA | | | | | | | | | | | | | | |
| | 11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 1956-1963 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: White | | | | | | | | | | | | | | |
| | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Submariner | | 16b. Kind of Business/Industry U.S. Navy | | | | | | | | | | | | | | | | |
| | 17. Father's Name (First, Middle, Last) Draper Frew Henry | | | | 18. Mother's Name (First, Middle, Maiden Surname) Mariam Knowles | | | | | | | | | | | | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print) Nancy E. Henry/wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1235 Timberturn, Arnold, MD 21012 | | | | | | | | | | | | | | | | |
| | 20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory | | Date 12-2-97 | | 20c. Location - City or Town, State Baltimore, MD | | | | | | | | | | | | | | |
| | 21. Signature of Funeral Service Licensee Robert S. [Signature] | | 22. Name and Address of Facility Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy., Severna Park, MD 21146 | | | | | | | | | | | | | | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | | | | | | | | | |
| | <table border="0"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a.</td> <td>Respiratory Arrest</td> <td rowspan="4">Approximate Interval Between Onset and Death</td> </tr> <tr> <td>b.</td> <td>Due to (or as a consequence of): Metastatic Disease to Liver</td> <td>minutes</td> </tr> <tr> <td>c.</td> <td>Due to (or as a consequence of): Colon Cancer</td> <td>weeks</td> </tr> <tr> <td>d.</td> <td>Due to (or as a consequence of):</td> <td>unknown</td> </tr> </table> | | | | | | | | Immediate Cause (Final disease or condition resulting in death) | a. | Respiratory Arrest | Approximate Interval Between Onset and Death | b. | Due to (or as a consequence of): Metastatic Disease to Liver | minutes | c. | Due to (or as a consequence of): Colon Cancer | weeks | d. | Due to (or as a consequence of): | unknown |
| | Immediate Cause (Final disease or condition resulting in death) | a. | Respiratory Arrest | Approximate Interval Between Onset and Death | | | | | | | | | | | | | | | | | |
| b. | | Due to (or as a consequence of): Metastatic Disease to Liver | minutes | | | | | | | | | | | | | | | | | | |
| c. | | Due to (or as a consequence of): Colon Cancer | weeks | | | | | | | | | | | | | | | | | | |
| d. | | Due to (or as a consequence of): | unknown | | | | | | | | | | | | | | | | | | |
| 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | | | | | | | | | | | | |
| 23c. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | | | | | | | | | | | | | | | |
| 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | | |
| 25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | | |
| 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | | | | | | | | | | | | | |
| 27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | | | | | | | | | | | | | | | | | | | | |
| 28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 28d. Describe how Injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | | | | | | | | | | | | |
| 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | | | | | | | | | | | |
| 29b. Signature and title of certifier Charles E. King M.D. | | | | | | | | | | | | | | | | | | | | | |
| 29c. License number D 41618 | | | | | | | | | | | | | | | | | | | | | |
| 29d. Date signed (Month, Day, Year) 12/1/97 | | | | | | | | | | | | | | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles E. King M.D. 621 Ridgely Avenue Suite 201 Annapolis MD 21401 | | | | | | | | | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year) DEC 04 1997 | | | | | | | | | | | | | | | | | | | | | |
| 32. Registrar's Signature Julia Davidson-Randall | | | | | | | | | | | | | | | | | | | | | |

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

4-11-53

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38991

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ALMA L. HILLIARD

2. Date of Death

Month Day Year
NOV. 29 1997

3. Time of Death

1508

4a. Facility Name (If not institution, give street and number)

ANNE ARUNDEL MEDICAL CENTER

4b. City, Town, or Location of Death

ANNAPOLIS

4c. County of Death

ANNE ARUNDEL

5. Social Security Number

430-20-4950

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

89

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
MARCH 25 1908

9. Birthplace (State or Foreign Country)

VIRGINIA

Usual Residence of Decedent

10e. State

MARYLAND

10b. County

ANNE ARUNDEL

10c. City, Town or Location

ANNAPOLIS

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3546 NARRAGANSETT AVE.

10f. Zip Code

21403

10g. Citizen of What Country?

US

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4 or 5+)

4+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

TEACHER

16b. Kind of Business/Industry

ANNE ARUNDEL CO.
BOARD OF EDUCATION

17. Father's Name (First, Middle, Last)

JAMES GOODE

18. Mother's Name (First, Middle, Maiden Surname)

MAGGIE DAVIS

19a. Informant's Name/Relationship (Type, Print)

MARGARET Y. WARD

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

13 FORBES BLVD. EASTCHESTER, NEW YORK, 10709

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

HILL CREST CEMETERY

Date

12/4/97

20c. Location - City or Town, State

ANNAPOLIS, MD.

21. Signature of Funeral Service Licensee

Larry H. Reese

22. Name and Address of Facility

WM. REESE & SONS MORTUARY, P.A.
821 WEST ST. ANNAPOLIS, MD. 21401

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Chronic Renal failure

b. End Stage Renal disease

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 yrs

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Senile Dementia; Alzheimer's disease; Hypertension; S/P CVA; Recurrent UTI

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

E. A. Hilliard

29c. License number

008453

29d. Date signed (Month, Day, Year)

12/01-97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

1833A Forest Dr Annapolis MD 21401

31. Date filed (Month, Day, Year)

DEC 05 1997

32. Registrar's Signature

Julia Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

2400
Cable - East London
Cable - East London

London, 11/11/1914
The London
The London

PP-10/11 2720-10-11
10/11 2720-10-11

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38992

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Thelma Jeanne Harbaugh

2. Date of Death

December 3 1997

3. Time of Death

09:10 AM

4a. Facility Name (If not institution, give street and number)

Harford Memorial Hospital

4b. City, Town, or Location of Death

Harre de Grace

4c. County of Death

Harford

Funeral
Director

5. Social Security Number

234-42-5226

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

68 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

5/15/29

9. Birthplace (State or Foreign Country)

West Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Harford

10c. City, Town or Location

Bel Air

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2912 Goat Hill Road

10f. Zip Code

21015

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
10

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Clarence Wesley Rake

18. Mother's Name (First, Middle, Maiden Surname)

Mildred Loraine Eagle

19a. Informant's Name/Relationship (Type, Print)

Linda J. Bennett/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2912 Goat Hill Road, Bel Air, MD 21015

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Angel Hill Cemetery

Date

12/6/97

20c. Location - City or Town, State

Havre de Grace, MD

21. Signature of Funeral Service Licensee

Stephen L. Hughes

22. Name and Address of Facility

Howard K. McComas III Funeral Home, P.A.
1317 Cokesbury Road, Abingdon, Maryland 21009

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. anoxic brain damage

Due to (or as a consequence of):

b. Cerebral Vascular accident

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

John Sampson

29c. License number

D43109

29d. Date signed (Month, Day, Year)

12/3/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

John B. Sampson, MD

501 S. Union Ave
Havre de Grace, MD 21078

31. Date filed (Month, Day, Year)

DEC 4 1997

32. Registrar's Signature

John B. Sampson

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38993

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

RANDOLPH HIGHTOWER

2. Date of Death

Month
Day
Year

DECEMBER 8, 1997

3. Time of Death

6:30 AM

4a. Facility Name (If not institution, give street and number)

MERCY MEDICAL CENTER

4b. City, Town, or Location of Death

BALTIMORE, MARYLAND

4c. County of Death

BALTIMORE CITY

Funeral
Director

5. Social Security Number

213-76-6294

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

38 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

FEBRUARY 5, 1959

9. Birthplace (State or Foreign Country)

Wash. D.C.

Usual Residence of Decedent

10e. State

Maryland

10b. County

Prince Georges

10c. City, Town or Location

Landover -

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

8147 Allendale Drive

10f. Zip Code

20785

10g. Citizen of What Country?

U.S.A

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

DISABLED

16b. Kind of Business/Industry

N/A

17. Father's Name (First, Middle, Last)

Cornelius J. Hightower

18. Mother's Name (First, Middle, Maiden Surname)

Inez BayLock

19e. Informant's Name/Relationship (Type, Print)

Inez Hightower/mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8147 Allendale Drive, Landover, Md 20785

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Harmony Memorial Park

Date

12/1/97

20c. Location - City or Town, State

Landover, Md

21. Signature of Funeral Service Licensee

Larry L. Simmons

22. Name and Address of Facility

Home Pope Funeral Home
5538 Monteboro Pike - Forestville, MD

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Urosepsis

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

☒ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home

5 ☐ Residence

6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

JAMES W. WALKER MD

29c. License number

P10221

29d. Date signed (Month, Day, Year)

12/8/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

JAMES WALKER

301 ST. PAUL STREET, BALTIMORE, MD 21202

31. Date filed (Month, Day, Year)

DEC 11 1997

32. Registrar's Signature

J. H. HIGHTOWER

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23e-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

38994

| | | | | | | | | | | |
|-------------------------------------|--|--|--|--|--|--|---|--|--|--|
| Physician /Medical Examiner | 1. Decedent's Name (First, Middle, Last) <u>Elaine Henson</u> | | | | 2. Date of Death Month <u>12</u> Day <u>18</u> Year <u>97</u> | | | | 3. Time of Death <u>9:00 A</u> | |
| | 4a. Facility Name (If not institution, give street and number) <u>Ann George Hospital</u> | | | | 4b. City, Town, or Location of Death <u>Cherry Hill</u> | | | | 4c. County of Death <u>Anne George</u> | |
| Funeral Director | 5. Social Security Number <u>N/A</u> | | 6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday) <u>30</u> Yrs. | | If Under 1 Year Months Days | | If Under 24 Hrs. Hours Min. | |
| | 8. Date of Birth (Month, Day, Year) <u>FEB 23, 1967</u> | | 9. Birthplace (State or Foreign Country) <u>PHILIPPINES</u> | | 10a. State <u>MD</u> | | 10b. County <u>P.G. COUNTY</u> | | 10c. City, Town or Location <u>HYATTSVILLE</u> | |
| To Be Completed by Funeral Director | 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 10e. Street and Number <u>7100 COLLEGE HEIGHTS DR</u> | | 10f. Zip Code <u>20783</u> | | 10g. Citizen of What Country? <u>PHILIPPINES</u> | | 11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | |
| | 12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc. Specify: <u>FILIPANO</u> | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>6</u> College (1-4 or 5+) <u>6</u> | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>STUDENT</u> | |
| | 16b. Kind of Business/Industry <u>GRAD SCHOOL</u> | | 17. Father's Name (First, Middle, Last) <u>NICOLAS HENSON</u> | | 18. Mother's Name (First, Middle, Maiden Surname) <u>IMELDA GARCIA</u> | | 19a. Informant's Name/Relationship (Type, Print) <u>RAMONA ABSALON/AUNT</u> | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>7100 COLLEGE HEIGHTS DR HYATTSVILLE MD 20783</u> | |
| | 20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place) <u>LOYOLA MEM PARK</u> | | Date <u>12-19-97</u> | | 20c. Location - City or Town, State <u>MARIKINA RIZAL PHILIPPINES</u> | | 21. Signature of Funeral Service Licensee <u>Joyce Houtgomey-Cheatham</u> | |
| | 22. Name and Address of Facility <u>ALEXANDER S. POPE FUNERAL HOME</u> <u>5538 MARLBORO PIKE FORESTVILLE MD 20743</u> | | 23a. Part I. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. <u>Massive Intracerebral Hemorrhage</u> Due to (or as a consequence of): a. <u>Massive Intracerebral Hemorrhage</u> b. <u>Due to (or as a consequence of):</u> c. <u>Due to (or as a consequence of):</u> d. <u>Due to (or as a consequence of):</u> | | 23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| | 25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input checked="" type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) <u>12-07-97</u> | | 28b. Time of Injury <u>12:55 PM</u> | |
| | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred <u>DRIVER OF AUTO VS AUTO COLLISION</u> | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <u>STREET</u> | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) <u>MARYLAND CHERRY HILL ROAD COLLEGE PARK</u> | | 29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | |
| | 29b. Signature and title of certifier <u>V. K. M.D.</u> | | 29c. License number <u>043830</u> | | 29d. Date signed (Month, Day, Year) <u>12/18/97</u> | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>Vicki Paul 3321 Toledo Terrace P.O. Hyattsville MD</u> | | 31. Date filed (Month, Day, Year) <u>DEC 11 1997</u> | |
| | 32. Registrar's Signature <u>V. K. M.D.</u> | | 33. Registrar's Title <u>Registrar</u> | | 34. Registrar's Address <u>3321 Toledo Terrace P.O. Hyattsville MD</u> | | 35. Registrar's Phone <u>3321 Toledo Terrace P.O. Hyattsville MD</u> | | 36. Registrar's Fax <u>3321 Toledo Terrace P.O. Hyattsville MD</u> | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Pelvic FractureMotor Vehicle Accident23b. Did tobacco use contribute to the cause of death?
1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy performed?
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No25. Was case referred to medical examiner?
1 ☒ Yes 2 ☐ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural2 ☒ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

32. Registrar's Signature

33. Registrar's Title

34. Registrar's Address

35. Registrar's Phone

36. Registrar's Fax

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38995

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

JOHN WAYNE HENDERSON

2. Date of Death

December 8 1997 4:15 pm

3. Time of Death

4a. Facility Name (If not institution, give street and number)

Magnolia Gardens Nursing Homes

4b. City, Town, or Location of Death

Lanham

4c. County of Death

Prince George's

Funeral
Director

5. Social Security Number

463-09-2227

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

78 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Feb. 13, 1919

9. Birthplace (State or Foreign Country)

Arkansas

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Lanham

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

5425 Whitfield Chapel Road

10f. Zip Code

20706

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give

Year or Dates: 1941-

1945

13. Was Decedent of Hispanic Origin? (Specify Yes or No

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Delivery Person

16b. Kind of Business/Industry

Thompson Dairy

17. Father's Name (First, Middle, Last)

Chris Henderson

18. Mother's Name (First, Middle, Maiden Surname)

Sally Rodrigues

19a. Informant's Name/Relationship (Type, Print)

Hilda Henderson - Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5425 Whitfield Chapel Road, Lanham, Maryland 20706

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Metropolitan Crematory

Date

12/10/97

20c. Location - City or Town, State

Alexandria, Virginia

21. Signature of Funeral Service Licensee

Francis Gasch's Sons Funeral Home, P.A.

22. Name and Address of Facility

4739 Baltimore Avenue, Hyattsville, MD 20781

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. Pepsis

Due to (or as a consequence of):

b. Clostridium Deferri toxin

Due to (or as a consequence of):

c. Colitis

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

10 days

2 days

6 days

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Parkinson's disease

Atrial fibrillation

Dementia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28. Place of Death (Check only one)

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how Injury occurred

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

R. Montgomery MD

29c. License number

D16273 MD

29d. Date signed (Month, Day, Year)

12/8/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6130 Landover Rd

Landover MD 20815

State
Registrar

31. Date filed (Month, Day, Year)

DEC 11 1997

32. Registrar's Signature

John Henderson

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Journal of Management Studies, 19(1), 67-80.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38996

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Angelina Ann Hall

2. Date of Death

December 7, 1997

3. Time of Death

12:15 P.M.

4a. Facility Name (If not institution, give street and number)

101 Elm Ave.

4b. City, Town, or Location of Death

Takoma Park

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

240-24-7128

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

75 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

July 26, 1922

9. Birthplace (State or Foreign Country)

South Carolina

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Takoma Park

10d. Inside City Limits

XX Yes 2 ☐ No

10e. Street and Number

101 Elm Ave.

10f. Zip Code

20912

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ MarriedXX 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: white

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Office Manager

16b. Kind of Business/Industry

Construction Company

17. Father's Name (First, Middle, Last)

Antonio Izzi

18. Mother's Name (First, Middle, Maiden Surname)

Carmela Dimeo

19a. Informant's Name/Relationship (Type, Print)

John M. Hall/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

16808 Oak Hill Rd. Silver Spring, MD 20905

20a. Method of Disposition

XX 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Gate of Heaven Dec. 11, 1997

Data

20c. Location - City or Town, State

Silver Spring, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Takoma Funeral Home, Inc.

254 Carroll St. NW Washington, DC 20012

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)a. Arteriosclerotic Heart Disease 2 years
Due to (or as a consequence of):Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending

Investigation

6 ☐ Could not be

determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D08546

29d. Date signed (Month, Day, Year)

Dec 7 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

John T. Weber

8218 Wisconsin Ave

Bethesda

31. Date filed (Month, Day, Year)

DEC 11 1997

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

perm. 2. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

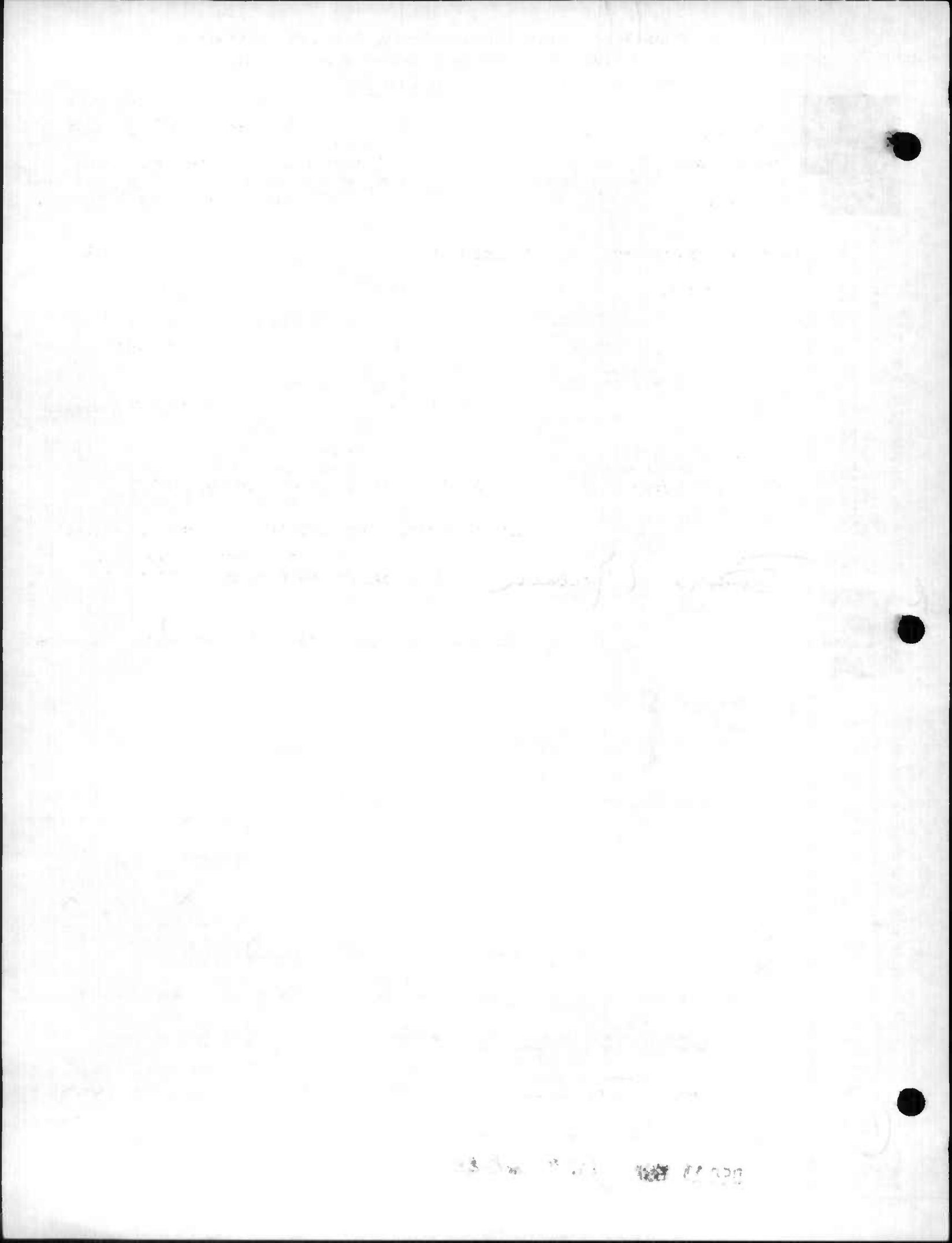
Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10

State
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38997

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

John Thomas Hayes

2. Date of Death

Month Day Year
December 4, 1997

3. Time of Death

8:00 pm

4a. Facility Name (If not institution, give street and number)

#12 Patuxent Mobile Estates

4b. City, Town, or Location of Death

Lothian

4c. County of Death

Anne Arundel

Funeral
Director

5. Social Security Number

213-12-1750

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

83

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Aug. 4, 1914

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Lothian

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

#12 Patuxent Mobile Estates

10f. Zip Code

20711

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
8

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Diesel Mechanic

16b. Kind of Business/Industry

Trailways Bus Company

17. Father's Name (First, Middle, Last)

John Thomas Hayes, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Unknown

19a. Informant's Name/Relationship (Type, Print)

Abdul Umar - Personal Representative

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2031 Brooks Drive #501, Forrestville, MD 20747

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Epiphany Episcopal Church Cemetery 12/12/97 Forrestville, MD

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Francis Gasch's Sons Funeral Home, P.A.
4739 Baltimore Avenue, Hyattsville, MD 2078123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a.

Atrial Tachycardia

Due to (or as a consequence of):

b.

Sinus bradycardia

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Approximate
Interval Between
Onset and Death

6 mo

10 yrs

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic Pernicious Anemia

Alcoholic Cirrhosis

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury at
Work?
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D38563

29d. Date signed (Month, Day, Year)

December 8, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Wayne Bierbaum, M.D. 134 Owensville Road, West River, Maryland 20778

31. Date filed (Month, Day, Year)

DEC 09 1997

32. Registrar's Signature

Baltimore, Maryland 21215-0020

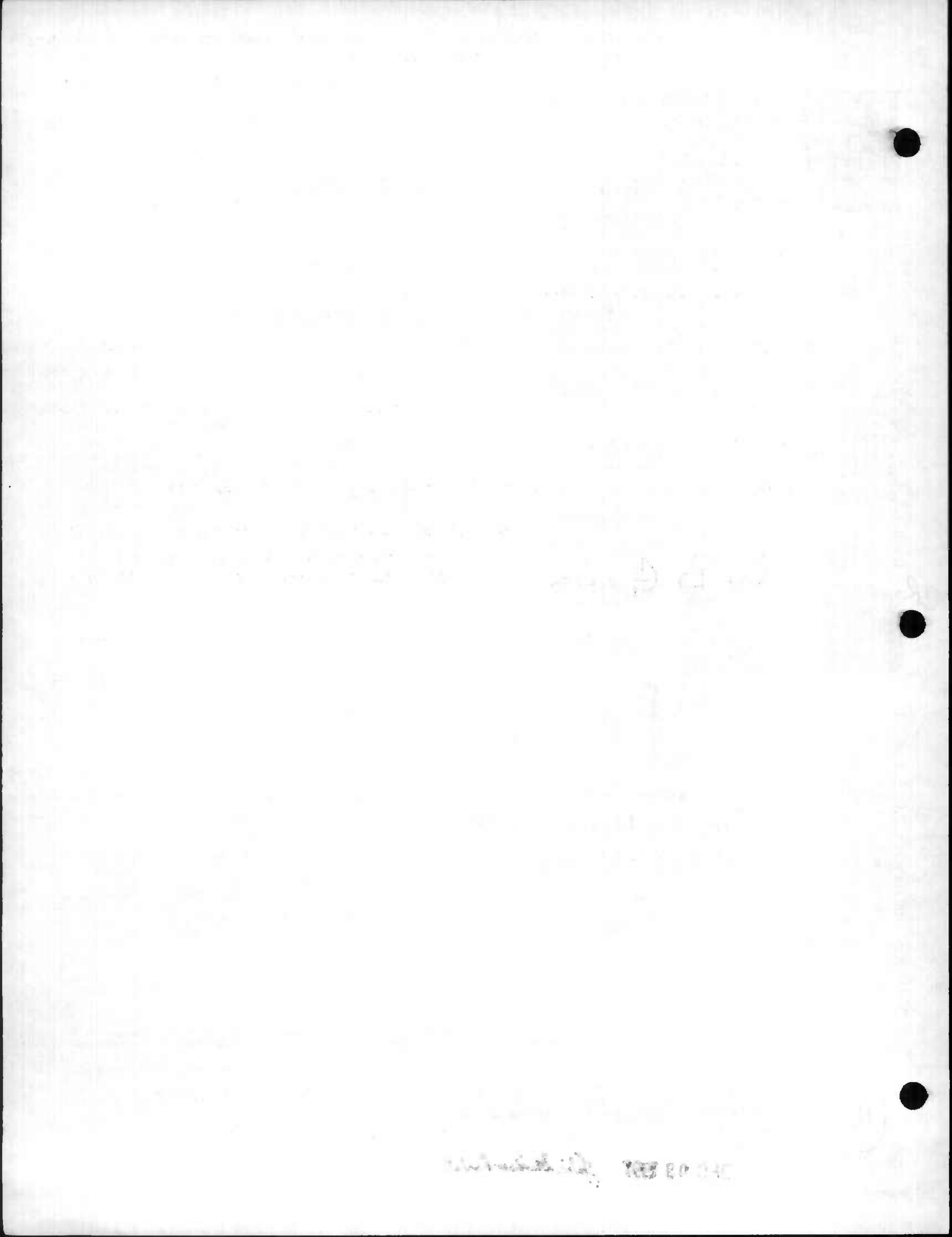
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 38998

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Thelma E. Harding

2. Date of Death

Month Day Year
December 4, 1997

3. Time of Death

8:30pm

4a. Facility Name (If not institution, give street and number)

Doctor's Community Hospital

4b. City, Town, or Location of Death

Lanham

4c. County of Death

Prince George's

Funeral
Director

5. Social Security Number

577-26-2948

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

74

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year
May 28, 1923

9. Birthplace (State or Foreign Country)

Washington, D.C.

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Greenbelt

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

7004 Hanover Parkway #1B

10f. Zip Code

20770

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Statistician

16b. Kind of Business/Industry

Federal Government

17. Father's Name (First, Middle, Last)

William Matthew Garner

18. Mother's Name (First, Middle, Maiden Surname)

Mildred Mathias

19a. Informant's Name/Relationship (Type, Print)

Dennis P. Harding/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Same as item 10

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metropolitan Crematory

Date

12/5/97

20c. Location - City or Town, State

Alexandria, Va.

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

George P. Kalas Funeral Home
6160 Oxon Hill Rd. Oxon Hill, Md. 20745

23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of death line.

Immediate Cause (Final disease or condition resulting in death)

a. Respiratory failure

Due to (or as a consequence of):

b. Congestive Heart failure

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 Day

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes Mellitus

Hypertension

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

28. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature] Dr. P. Singh MD

29c. License number

D45666

29d. Date signed (Month, Day, Year)

12-5-97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

DRINDER SINGH, MD 3000 MITCHELLVILLE ROAD POWIE, MD 20716

31. Date filed (Month, Day, Year)

DEC 08 1997

32. Registrar's Signature

[Signature]

State
Registrar

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 21 is marked other than "natural", or items 23a or 23e-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020

Thelma Harding
CR

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 38999

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

GEORGE HENDERSON

2. Date of Death

Month Day Year

12 04 97

3. Time of Death

4:00 AM

4a. Facility Name (If not institution, give street and number)

MED LANTIC MANOR AT LAYHILL

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery County

Funeral
Director

5. Social Security Number

226-18-9122

6. Sex

M F

7. Age (In yrs. last birthday)

74

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

12 /25/22

9. Birthplace (State or Foreign Country)

Nelson Co., VA

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1X Yes 2X No

10e. Street and Number

2601 Bel Tre Road

10f. Zip Code

20906

10g. Citizen of What Country?

USA

11. Marital Status

1X Never Married 2X Married

3X Widowed 4X Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1X Yes 2X No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1X Yes 2X No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

7th

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Stock Clerk

16b. Kind of Business/Industry

Federal Government

17. Father's Name (First, Middle, Last)

William Henderson

18. Mother's Name (First, Middle, Maiden Summa)

Georgene Henderson

19a. Informant's Name/Relationship (Type, Print)

Greta Al-Amin-El/daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2103 Willowtree Lane Temple Hills, Md. 20748

20a. Method of Disposition

1X Burial 2X Cremation 3X Removal from State

4X Donation 5X Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Cheltenham

Date

12/11/97

20c. Location - City or Town, State

Cheltenham Md.

21. Signature of Funeral Service Licensee

W.G. Jeffers

22. Name and Address of Facility

Frazier's Funeral Home

389 Rhode Island Avenue, N.W. Washington, DC

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Atherosclerotic Cardiovascular disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Cerebral Aneurysm

23b. Did tobacco use contribute to the cause of death?

1X Yes 2X No 3X Probably 4X Unknown

24a. Was an autopsy performed?

1X Yes 2X No

24b. Were autopsy findings available prior to completion of cause of death?

1X Yes 2X No

25. Was case referred to medical examiner?

1X Yes 2X No

Hospital:

1X Inpatient 2X ER/Outpatient 3X DOA

28. Place of Death (Check only one)

4X Nursing Home 5X Residence 6X Other (Specify)

27. Manner of Death

1X Natural 5X Pending investigation
2X Accident 6X Could not be determined
3X Suicide
4X Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1X Yes 2X No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1X Certifying Physician To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2X Medical Examiner On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and Title of Certifier

Brynn Aronson, MD

29c. License number

MD 108381

29d. Date signed (Month, Day, Year)

December 4, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Brynn Aronson, MD 1811 Prince Philip Dr. Chevy Chase, MD 20815

31. Date filed (Month, Day, Year)

DEC 08 1997

32. Registrar's Signature

Shirley Anderson-Rodak

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

[Faint, illegible text covering the upper and middle portions of the page, possibly bleed-through from the reverse side.]

on the night of Friday 21st Dec. 1980
at the time of the ...
... 1980 ...

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 39000

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Robert O

2. Date of Death

Month 8, Day 1997

3. Time of Death

11:10 PM

4a. Facility Name (If not institution, give street and number)

Southern Maryland Hospital

4b. City, Town, or Location of Death

Clinton

4c. County of Death

Prince Georges

Funeral
Director

5. Social Security Number

579-03-2330

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

82 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

February 4, 1915

9. Birthplace (State or Foreign Country)

SOUTH CAROLINA

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

PRINCE GEORGE'S

10c. City, Town or Location

UPPER MARLBORO

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

10301 PRINCE CHARLES COURT

10f. Zip Code

20772

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married

3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: 26 OCT 43 - 26 NOV 45

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12) College (14 or 5+)

10th

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

MAIL CLERK

16b. Kind of Business/Industry

U.S. POSTAL SERVICE

17. Father's Name (First, Middle, Last)

ZONNIE HOLLOWAY

18. Mother's Name (First, Middle, Maiden Surname)

MATTIE DOZIER

19a. Informant's Name/Relationship (Type, Print)

AARON HOLLOWAY/SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10301 PRINCE CHARLES CT. UPPER MARLBORO, MD 20772

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

LINCOLN CEMETERY

Date

12-12

20c. Location - City or Town, State

SUITLAND, MD

21. Signature of Funeral Service Licensee

Kimberly C. Buscra-Tonic

22. Name and Address of Facility

MARSHALL'S FUNERAL HOME 4308 SUITLAND ROAD SUITLAND, MD 20746

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. Acute myocardial infarction Due to (or as a consequence of):

b. Cardiac perforating aneurysm Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 months

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide

5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

2 ☒ Medical Examiner

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Glenn Jackson 7450 Penn. Ave. #18 Upper Marlboro MD 20772

31. Date filed (Month, Day, Year)

DEC 12 1997

32. Registrar's Signature

John H. H. H. H.

State Registrar

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